EMOTION AND ADVENTURE THERAPY: A MODEL

A thesis submitted in partial fulfilment
for the requirements for the degree of
Master of Arts in Psychology
by

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1998

CONTENTS

Preface

The cognitive *zeitgeist* within the psychotherapy literature of the last decades has tended to obscure the role of emotion, emphasising instead the role of cognition and behaviour in psychotherapeutic change. It seems anomalous that clinically oriented psychologists should have neglected emotion to such a degree, as emotional distress of one type or another is the currency of psychotherapy. Concurrent with the neglect of emotion in the psychotherapy literature, within general psychology there has been a resurgence of interest in emotion as a fundamental aspect of human experience. Following the course set by Jeremy Safran & Leslie Greenberg, the individuals who have alerted the psychotherapeutic community to the need for cognisance of the general psychology work on emotion, an attempt has been made to form an amalgam which acknowledges both the therapeutic and academic knowledge about emotion. That is the first element of the discussion presented below.

The second major element is Adventure Therapy. Adventure Therapy, as a means of addressing difficulties of various sorts, has been a part of the therapeutic landscape for almost one hundred years. There has been a recent resurgence of interest in Adventure Therapy, particularly as the need for alternatives to traditional 'talking' therapies for some populations has been recognised. The view taken here is that Adventure Therapy is

indeed a form of psychotherapy and not merely a specialised form of recreation undertaken with particular populations.

In much the same way as many other forms of therapy, Adventure Therapy is partially defined by the environment, procedures and techniques which constitute the practical aspect of the approach. Behind this is the theory that provides the rationale for the more tangible aspects. For instance, classical psychoanalysis has the unconscious, free association, and the ubiquitous couch, while Adventure Therapy has the outdoors and activities such as climbing, abseiling, kayaking, and tramping. As will become apparent, for Adventure Therapy, it is the activities and the environment within which they take place that is crucial to the therapeutic effect.

Most psychotherapeutic schools, to greater or lesser degrees, have attempted, in the course of their theorising, to say something about the role of emotion. This does not appear to be the case for Adventure Therapy. By way of redressing this notable deficiency, the discussion below draws on the implications that stem from a synthesis emerging from both the therapeutic and academic literatures.

Chapter 1 is an introduction to Adventure Therapy with particular emphasis on the existing theoretical models which have been applied to Adventure Therapy. Also discussed are the types of programs which exist and the populations to which they are

directed. Similarly, Chapter 2 delineates a number of features of emotion drawing on the general academic research and theory.

Chapter 3 outlines the ways in which various psychotherapeutic schools have conceptualised emotion. The emotional change processes which contribute to the purported psychotherapeutic effect are also examined. Chapter 4 describes the general therapeutic implications that emerge from the synthesis of the therapeutic and academic literatures.

Chapter 5 is an examination of two particular bodies of research that relate to both emotion and adventure; coping and risk-taking. The purpose of this chapter is to demonstrate that the academic research provides some useful signposts as to the role of emotion in Adventure Therapy particularly with regard to the complexity of the factors which may need to be considered when examining adventure specifically. However, what also becomes apparent are the limitations of scope and methodology that will need to be addressed for research within the Adventure Therapy context.

Chapter 6 presents a model of the role of emotion in Adventure Therapy. The model, essentially an ecological constructivist analysis, draws on the preceding chapters and is designed to provide a starting point from which a research program can be undertaken. It suggests that the activities and processes which are inherent parts of Adventure Therapy provide an adaptive context

within which emotion plays a central therapeutic role by way of its ability to penetrate multiple aspects of being.

It is a common conceit that writing is a solitary task, but considering, even for a moment, the people who have assisted in the production of this thesis quickly bursts the bubble of self-importance. My supervisor, Professor Ken Strongman, listened patiently to my more outlandish ideas, supplied useful feedback on the text and provided an exemplary model of eruditeness. John Raynor, Margaret Grant-Caplan and Katie Hamilton, my colleagues at Richmond Fellowship's Adventure Based Learning Program, were always enthusiastic about the project and gave me chocolate fish at just the right times. My sister Rachel, and her husband Stephen, made the task of preparing the manuscript substantially easier with their intelligent proofing. My parents, Eric and Robyn, have been unfailingly encouraging and supportive throughout the course of my academic endeavours. My last thesis, in Sociology and Anthropology, was dedicated to them, so is this one - the subject has changed but their love has remained the same.

ADVENTURE THERAPY

The aim of this chapter is to introduce the area of Adventure Therapy. The first and most obvious difficulty when approaching the literature in this area is the plethora of terms which different authors and practitioners have used to describe their field - terms such as adventure therapy (Gass, 1991; Stein & Senior, 1984), adventure based counselling (Maizell, 1988: Shoel, Prouty and Radcliffe, 1988), experiential-challenge (Roland et al, 1987), outdoor-adventure pursuits (Ewert, 1989), therapeutic adventure programs (Wichmann, 1991), and wilderness therapy (Bacon & Kimball, 1989; Berman and Anton, 1988). At this point and for reasons of convenience rather than any particular ideological preference the term *Adventure Therapy* will be used.

Adventure education and therapy programs are becoming increasingly popular interventions to address a wide variety of client difficulties. Ewert (1989:6) suggested that such programs involve "a variety of self initiated activities ... that contain elements of real or apparent danger, in which the outcome, while uncertain, can be influenced by the participant and circumstance". Programs

generally involve participants in physically and mentally demanding activities such as rock-climbing, abseiling, canoeing, rafting, tramping, and caving.

There is a plethora of evaluation and outcome studies of various individual programs around the world as well as meta-analyses suggestive of positive outcomes (see for example; Berman, 1995; Cason & Gillis, 1994; Davis-Berman & Berman, 1989). However, Wichmann (1991) maintains that while it is generally accepted that such programs generally have at least some positive outcomes, what is still unclear is why these positive outcomes occur.

Described below are the main theoretical approaches used within the Adventure Therapy domain. While these approaches are generally grounded within psychological theory, philosophical, historical and cultural aspects are also outlined. This approach of only describing theoretical approaches reported within the Adventure Therapy literature has resulted in some notable omissions such as psychoanalytic and cognitive behavioural therapies. This is not to suggest that Adventure Therapy programs

do not utilise aspects of such therapeutic techniques but indicates instead a lack of literature explicitly linking Adventure Therapy with such approaches. The theoretical review is followed by a brief description of the types, target populations, and components of various Adventure Therapy programs.

Theoretical Approaches

The Wilderness Ethic

A fundamental aspect of most therapeutic undertakings is the 'healing setting' (Frank, 1979). This is generally taken to refer to the layout of the therapist's office, the assurance of confidentiality and safety, and the general context within which the encounter occurs e.g. a hospital, an outpatient unit, a prison, or professional rooms. Adventure Therapy, however, typically occurs outdoors and the therapeutic environment is generally separate from both the clients' and the therapists' everyday experience. The utilisation of the outdoor environment is one of the defining features of Adventure Therapy and is seen, to varying degrees and in various ways, as a key therapeutic element. The environmental aspect of Adventure Therapy is generally approached from two

perspectives; a 'romantic' view of the wilderness, where the experience of just being in a wild place is thought to have therapeutic import, and a view of the experience as being an 'escape', 'haven', or 'time out' that is used to facilitate therapy. The romantic approach essentially suggests that it is the place, that is, the wilderness, that acts as the therapist while the other 'escape' perspective sees the wilderness or outdoors as a useful therapeutic medium.

It is a recurring theme in Western culture that poets, philosophers, and prophets find vision and inspiration in the wilderness. It is important to note, however, that cultural interpretations of the wilderness vary markedly, and that societal attitudes towards the wilderness and adventure change substantially over time. Kluckhohn (1953) pointed out that cultures almost invariably speak of the meaning of nature and of their relationship to that meaning as central human concerns. Wilderness is a particular category of nature and prompts various questions. Does it provide a sanctuary or does it signify danger. Is it a representation of perfect order or

does it need to be subdued and organised (Altman & Chemers, 1980)?

For instance, for Jews in the time of the Roman Empire, wilderness was a sanctuary from oppressors. In the Judeo-Christian tradition, some individuals, such as Moses, John the Baptist, and Jesus sought out isolation in order to face God and learn spiritual truth. However, as time passed, Christian ideology came to see the wilderness as a place of spiritual confusion, physical danger, and earthly temptation. The wilderness became a place to be subdued and cultivated. Spiritual meaning came to be associated with human endeavour in the form of organisation and production, reaching its zenith in the 19th century Evangelical movement. In contrast to this view is the Eastern perspective which sees nature and wilderness experiences as fundamentally instructive, presenting the individual with a perspective on their place in both the cosmos and their own society (Needham, 1969).

The Romantic movement, which began in Europe in the eighteenth century, and infused the world of philosophy, art, and literature

with a new enthusiasm for nature. It is within American literature that the Romantic attitude towards the wilderness, and humanity's place within it, is most clearly espoused.[1] Longfellow, Whitman, and Emerson all popularised the appeal of the wilderness. It is, however, in the work of Thoreau that the romantic wilderness ethic is most clearly described (Burll, 1995). In *Walden Pond,* perhaps his best known work, Thoreau wrote:

> *I went to the woods because I wished to live deliberately, to front only the essential facts of life, and to see if I could not learn what it had to teach, and not, when I came to die, discover that I had not lived.* (1997:75)

Krutch (1982) suggests that *Walden Pond* contains four main themes, all of which still, to a greater or lesser degree, have resonance in the Adventure Therapy literature: (1) most people lead desperate lives that are maintained in silence; (2) this condition is brought about by a fallacy that has to do with materialism; (3) happiness comes from leading a simple life close to nature; and (4) leading this kind of life results in an understanding of 'higher principles'. Kaplan and Talbot (1983), referring specifically to Adventure Therapy wrote:

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[1] The other major influence that could be discussed here is Jean-Jacques Rousseau who produced a compelling critique of urban sophistication. In an unflattering analysis of the decidedly ramshackle life of Rousseau, Johnson (1988) writes, "he is the father of the cold bath, systematic exercise, sport as character-forming, the weekend cottage".

> *The wilderness matches some sort of intention of the way things ought to be, the way things really are beneath the surface layers of culture and civilisation* (p.190).

A rather more pragmatic approach, is described by Chase (cited in Handley, 1990:177):

> *A natural or wilderness environment is predictable. As a result, outcomes of dysfunctional behaviour are clear and easily understood. There are few rules other than those imposed by the environment ... there are no walls, little luxury and much freedom. There is freedom to accept and deny responsibility for ones self and others, to be clean and dirty, to hungry or well fed, to be miserable or to have fun. The consequences of burned oatmeal, of a sleeping bag left out in the rain or an improper belay are immediate and direct.*

While the negative consequences are powerful motivators for adapting behaviour, Handly (ibid) suggests that the positive consequences of appropriate behaviour within this environment are equally powerful. The individual is rewarded with spectacular views after persevering with a hard climb, a canoeist progresses toward a goal after successfully negotiating a difficult rapid, and so on. Aside from a rather behaviourist flavour to such a viewpoint, which may seem incongruous, the most obvious difficulties with this approach are its lack of specificity with regard to addressing identified problematic behaviours and its culturally determined, but

generally applied, assumptions about the rewards of being in the outdoors. There is also a hint of some sort of 'magic' occuring as a result of being in the wilderness, that because of its untestable nature, tends to make empirically oriented scientists rather suspicious.[2]

Withdrawal and Escape

The second perspective of the environment in the Adventure Therapy literature relates to the notion of withdrawal or escape. There is an intuitive appeal to such an approach reflected in such common sayings as 'getting away from it all'. The term 'escape' is generally employed to refer to an absence of some aspect of life that is ordinarily present. This could be at the level of getting away from the work one ordinarily does, finding a place free from usually present distractions (such as noise or crowds), or being away from a deleterious environment or situation such as an abusive releationship. While this aspect has been addressed in some early

[2] The ecopsychology movement, an amalgam of environmentalism, psycotherapy, and religion, is the most recent incarnation of such ideas, see Roszak *et al* (1995) for an overview of ecopsychology perspectives.

recreational literature (Hollender, 1977; Stringer, 1975), and is taken up below with regard to program types, it would appear to have been largely unaddressed within the psychological literature.

Outward Bound

Although Outward Bound is strictly a program type rather than a theoretical approach, the Outward Bound 'philosophy' has had a profound influence on the Adventure Therapy field. The origins of many contemporary Adventure Therapy programs can be traced to the Outward Bound programs originally developed by educationalist Kurt Hahn and shipping magnate Lawrence Holt in the 1940's (Wilson, 1981). Holt observed that younger sailors, trained on modern ships with sophisticated equipment, were less likely to survive shipwrecks than were their older counterparts who had trained on sailing vessels, where manual dexterity and teamwork were regarded as essential skills. Holt believed that the new generation of sailors lacked the physical resilience, resourcefulness, and emotional control that he maintained older sailors used to overcome the hazards of the sea. A curriculum was formulated by Hahn and Holt which included obstacle courses and

other 'challenges' ostensibly designed to address the perceived deficits in the young sailors.

The style adopted by the Outward Bound movement in the United Kingdom mirrored Hahn's approach to general education, most notably his austere and harsh public schools, such as Gordonstoun in Scotland. The rationale underlying the early Outward Bound programs was that individuals needed to develop confidence in their physical and psychological 'toughness' in the face of life-threatening conditions and that difficult experiences precipitate prosocial values. This is reflected in a commitment to what would now be described as 'traditional' values. Hahn wrote: "The foremost task of education is to ensure the survival of these qualities: an indefatigable spirit, tenacity in pursuit, readiness for sensible self denial, and, above all, compassion" (Richards, 1981:34). These values are still a key part of modern Outward Bound programs and are represented in Outward Bound's current learning objectives:

1. The learning of skills.

2. Personal development - self confidence, self concept, new directions, enhancement of personal philosophy and values.
3. Interpersonal effectiveness - develop relationships, learn to live with a variety of people from different backgrounds, learn group dynamic skills.
4. Environmental awareness - develop responsibility for preservation, conservation.
5. The transfer of learning back to reality (Martin, 1997).

The experiences that Hahn maintained were particularly conducive to the formation of such values were wilderness experiences and rescue training. Within these activities there was considerable pressure to develop the desired attributes, and failure to do so was explicitly linked to danger to the group, injuries, negative morale, and possible cessation of the activity for either the group or the individual (Salerno, 1994).

What is notable here is Hahn's notion of learning by *doing,* and that what participants were learning was oriented towards the

development of maturity and what Hahn called *character.* Hahn, while being deeply concerned about intellectual freedom (he himself had been imprisoned and subsequently deported from Germany by the Nazi regime) nevertheless felt that some form of compulsion was required. He wrote: "We believe it is the sin of the soul to force the young into opinions, but we consider it culpable neglect not to impel every youngster into health-giving experiences - regardless of their inclinations" (Richards, 1981:43).

The first Outward Bound to open in the United States was in Colorado in 1962. Outward Bound soon became involved in the 'treatment' of juvenile delinquents. Extending (or perhaps making more palatable) Hahn's original approach, Outward Bound programs were predicated on the purported relationship between self-esteem and delinquency. The essence of the approach was that individuals suffer from negative self-esteem and that if this was raised then the probability of delinquency or other maladaptive behaviour was reduced. The assumption is questionable and research results have been equivocal, with some research suggesting that an excess rather than lack of self-esteem

is associated with delinquency (Farrington, 1990). It has become increasingly apparent that the construct of self-esteem is rather broad, with self-esteem being a multifaceted rather than unitary construct and that the particular facets are situationally determined (Muran & Safran, 1993). It is notable however, that the majority of Adventure Therapy programs include enhancing self-esteem as a primary goal.

Outward Bound is, in many ways, the Alcoholics Anonymous of the Adventure Therapy world. Since 1945, Outward Bound has spread to five continents and includes 46 programs. Many thousands of other programs in schools, vocational programs, colleges, and social service agencies are modeled on Outward Bound. While Outward Bound's theoretical underpinnings are often questioned, as is its general approach, (most notably the use of relatively high levels of objective as opposed to perceived risk), it continues to be almost synonymous with Adventure Therapy.

General Systems Theory and Cybernetics

Beginning in the 1940s, Ludwig von Bertalanffy (1968) and others began to develop an ambitious but comprehensive theoretical model embracing all living systems. General Systems Theory was a direct challenge to the reductionist view prevalent in the sciences. The reductionist view was that complex phenomena could be best understood by carefully breaking them down into component parts. Within General Systems Theory, the focus is on the inter-relationships between parts. 'A' may cause 'B', but 'B' affects 'A', which in turn affects 'B', and so on, in a circular causality.

Gregory Bateson (1991) developed Cybernetics in the areas of anthropology, biology, and psychology, stating that changes in attitudes and behaviour occur as part of the process of responding to new information. Rather than looking back on the problem and seeking to define it in terms of past experiences or present complications, Cybernetics is solution focused. By changing present perceptions of the problem, solutions can be initiated. It is within the Family Therapy movement, particularly with the work of

Bowen (1978) and Minuchin (1974), that Cybernetics has been most powerfully articulated as a therapeutic paradigm.

Handley (1992) has posited that a Cybernetic approach can be usefully applied to the Adventure Therapy domain:

> *The wilderness is a powerful system. Relatively free from external forces, it provides the opportunity to explore new responses and develop new patterns of thought and behaviour. It provides a short but significant cybernetic model that develops a change in attitude for each participant, and the time to test and reinforce this change in a difficult environment. Feedback is often instantaneous, feelings of success and failure refining the process.* (1992:345)

While, as has been described above, the 'power' of the wilderness is often espoused, it is seldom conceptualised in these terms. The interactional nature of the wilderness experience means that intervention from therapists must be carefully applied because inappropriate intervention will diminish the interactional freedom of the experience. Such an approach is more compatible with a model of a therapist as a facilitator, rather than as didactic instructor.

Those in the Adventure Therapy area who use a Cybernetic model generally conceive of wilderness experiences as a different system for the participants' behaviour. For instance, because of the interdependence of family members and the tendency for systems to maintain stability (of whatever form), it is often difficult to change an individual's behaviour - without the assistance of the family system. An Adventure Therapy setting provides a different system for the individual's behaviour. Many commonly observed problem behaviours of adolescents (such as being withdrawn, uncooperative or verbally aggressive) are incompatible with a wilderness setting where participants need to cooperate and communicate. Furthermore, such positive behaviours are quickly integrated into the wilderness system whereas in the adolescents usual family system such behaviours may be not be as directly reinforced as they are 'outside the loop' of the system which is seeking to maintain stability.

The primary strength of the Cybernetic model in relation to Adventure Therapy is that it provides a possible explanation as to the 'why' of how Adventure Therapy may be effective. The

cybernetic nature of the experience is clearly evident to the participants because feedback is generally direct and tangible. The systems model does not, however, suggest the motive power or the 'how' of Adventure Therapy. If the experiences are to have direct relevance to the problematic aspects of the participant's life, it is necessary to have an explanation of what it is about the experiences that does the therapeutic work.

Tension Theory

Festinger (1957), following the work of Lewins (1951) who proposed that the stronger the tension before a decision is made the greater the tendency to carry through on that decision afterward, formulated a theory of cognitive dissonance. Briefly explained, cognitive dissonance is an inconsistency between present perceptions and reality that results in a change of perception to reduce the frustration or disequilibrium existing with the present reality.

The Adventure Therapy experience can be seen as a catalyst for dissonance, where the program is structured to maximise tension

in order to create a preposition for effective decision making. With regard to Adventure Therapy, it is important to recognise that this perspective, while encouraging conflict, does not promote confrontation. Confrontation occurs when two opposing views, for instance between two participants on a program, become polarised and entrenched. Rather, this approach seeks to use tension and conflict to promote problem solving and equilibrium (Kraft & Sakofs, 1985). This approach, while providing a possible explanation for the motivation to adopt new viewpoints or goals, does not provide an adequate explanation of how changes in cognitive equilibrium that occur within an Adventure Therapy setting might be maintained in the 'real world'. It would appear that to expect lasting change to occur, the adventure experience would need to have precedence over other experiences which may have occurred.

Social Learning Theory: Modelling, Self-efficacy, and Locus of Control

Modelling

Miller and Dollard, in their 1941 work *Social Learning and Imitation,* described two types of learning. The first is copying, where a learner matches the responses of the model. To use an Adventure Therapy example, an instructor may teach participants how to light a stove by modelling that behaviour and having them copy the essential steps of lighting the stove. The second type of learning, matched-dependent learning, involves a more experienced, skilled or older model who engages in behaviour to gain reinforcement, and a younger, less skilled, or less experienced learner who follows the leader because following has led to reinforcement for the novice. Miller and Dollard use a drive reduction model with the core constructs being drive, cue, response, and reinforcement. For example, consider a group leader who has a need for comfort (drive) and who then searches for a flat campsite on soft ground (cue), the leader then sets up camp (response), and relaxes (reward).

In the late 1960s and early 1970s, Bandura and his colleagues debated the drive reduction model and argued that behaviour could be acquired through observation without it being deliberately

demonstrated (Bandura,1971). Bandura (1986) maintains that there are four critical factors which will predict the likelihood that behaviour will be acquired through observation.

Firstly, attentional processes govern who and what is observed. The event will be evaluated with regard to things such as salience, complexity and value to the individual. The relative attractiveness of the model is also an important factor in the attentional process. Secondly, retention processes essentially involve the coding and cognitive organisation of the event. Cognitive and enactive rehearsals promote retention. Rehearsals of increasing complexity are a common part of the preparation for many Adventure Therapy activities. The third process contributing to observational learning concerns the actual production of the activity. Key parts of this process are the individual's physical abilities, ability to self observe, and feedback. Videotaping of activities is commonly employed to enhance feedback to the individual who can then see that they are sitting in the wrong place in a canoe, for instance. Lastly, motivational processes relate to the extent to which the modelled behaviour is rewarded. Reinforcements can be internal

("I feel great having done that"), external ("You did a great job on that rapid") or vicarious, with reinforcement occuring as the result of watching others being rewarded (or punished) for the same behaviour.

Self-efficacy

Any reference to Bandura with regard to Adventure Therapy leads almost inevitably to discussion of self-efficacy. Bandura (1997:3) states that perceived self-efficacy "refers to beliefs in one's capabilities to organise and execute the courses of action required to produce given attainments". Bandura goes on to point out that these beliefs influence the courses of action people choose to pursue, how much effort they will apply, how long they will persevere in the face of obstacles, their resilience to adversity, whether their thought patterns are self-hindering or self-aiding, how much stress and depression they experience, and lastly, the level of accomplishment they realise.

Perceptions of self-efficacy are supposed by Bandura (1986) to depend on four primary sources of information: performance

attainment, vicarious experiences of observing the performance of others, verbal persuasion, and allied types of social influences that an individual posses competence, and lastly physiological states that individuals use to judge their capability, strength, and vulnerability. All these sources have obvious relevance to the Adventure Therapy context. Of particular interest to therapists working in the Adventure Therapy realm has been the limited effectiveness of verbal persuasion, which is the basis of most psychotherapies, and the powerful impact of performance attainments on perceived self-efficacy (Sachs & Miller, 1992). Performance attainments are most powerful because they involve actual attempts to master the environment. Adventure Therapy programs typically involve participants in achieving mastery over aspects of their behaviour in the outdoor environment. The primary difficulty that researchers have had is linking increased self-efficacy for the activities that are part of Adventure Therapy programs with more general improvements.[3] There is a marked tendency with the Adventure Therapy literature to associate and

[3] see Maddux (1995) for a general review.

essentially confound improvements in self-efficacy with changes in self-esteem or self-concept.

Locus of Control

One of the most often referred to changes for participants on Adventure Therapy programs is an increased feeling of responsibility for the events in their lives (Cason & Gillis, 1994; Latess, 1992). This type of change has most commonly been associated with Rotters (1954) notions of internal versus external locus of control. An external locus of control suggests that individuals feel that they are not responsible for the outcomes of their actions, that is, whether or not they get rewards is a function of luck, fate, or others - external factors. Alternatively, an internal locus indicates a belief that outcomes are a function of effort, skill, personality or other internal factors. An internal locus of control is generally considered to be a desirable factor and is associated with more active engagement with the environment, as opposed to the more fatalistic outlook of those with an external locus of control (Rotter,1982).

Self-Esteem:

Conceptions of self-esteem have a central role in modern personality psychology that can be traced back to William James (Hattie,1992). One of the most commonly claimed benefits of Adventure Therapy programs is an improvement in participants' self-esteem.[4] However there is no one theory of self-esteem and it would appear that improvement in self-esteem is the *goal* of a number of therapeutic perspectives rather than a theoretical approach *per se*. Various Adventure Therapy approaches seek to facilitate improvements in self-esteem from within a number of theoretical approaches. It is notable that the expectation that almost automatic improvements in self-esteem will occur as the result of participation is increasingly being called into question (Kemp, 1997).

Reality therapy:

[4] See Ewert (1983) for a review of the use and measurement of self-esteem in Adventure Therapy programs.

Clagett (1992) describes the application of William Glasser's (1975) Reality Therapy to Adventure Therapy. Reality therapy proposes that it can help people change because it is based on how people live from moment to moment. Glasser maintained that people have more control over their actions, thinking, and feelings than they have been led to believe through popular culture and some of the more deterministic psychological theories (Glasser himself was a psychoanalytically trained psychiatrist). Following the theoretical work of Powers (1973), Glasser maintained that all humans, regardless of cultural background, are motivated by five 'forces': the desire to survive, the psychological need of belonging, power (in the form of achievement, competence and accomplishment), enjoyment, and freedom (the opportunity to make choices and act autonomously). With these principles in mind, Glasser formulated seven principles that guide therapeutic interventions, all of which have direct application within an Adventure Therapy setting. The seven principles are:

1. Involvement - the individual needs to become positively involved with others, including the therapist.

2. Having the client acquire awareness of their current behaviour - subsequent to becoming positively involved, the individual is guided into becoming consciously aware of his or her problematic behaviour. The therapist is constantly asking the client "what are you doing?".
3. The client is then encouraged to evaluate his or her behaviour by critically examining whether or not their behaviour is serving his or her best interests, whether the behaviour is 'good' for those to whom the client is close and the wider community.
4. Planning responsible behaviour - in collaboration with the therapist other feasible behavioural options are formulated.
5. The client is asked for a commitment, which is usually verbal, that the plan for more responsible behaviour will be carried out. This has two primary aims, firstly to intensify and accelerate the client's efforts to try new behavioural options, and secondly, to encourage the client to recognise the importance of keeping commitments to others generally.
6. The therapist accepts no excuses for failure to fulfil a commitment. Glasser's main concern regarding this point

was that the client should not be able to find an 'easy way' out of commitments which they have made and that excuses are not indicative of success.

7. Punishment is not employed. Hierarchically imposed punishment is supposed to erode the positive involvement which is necessary for clients to succeed in solving their behavioural problems. There is, therefore, no ridicule or withdrawal but rather the application of previously agreed upon consequences of irresponsible behaviour.

Reality Therapy approaches were among the first to explicitly attempt to integrate the fact that the vast majority of Adventure Therapy interventions are undertaken in small, usually interdependent, groups. Clients are encouraged to identify with their group (a 'reference group' in Reality Therapy parlance).

Reality Therapy style approaches are particularly amenable to Adventure Therapy settings, especially those programs based on extended wilderness expeditions. Activities can be formulated and examined in terms of the principles described above. Another

appealing aspect of Reality Therapy is its largely non-technical nature and accessibility (Glasser & Wubbolding, 1996). Reality Therapy as a therapeutic modality has achieved support in a number of settings, particularly those that deal with 'behavioural' problems. However its theoretical underpinnings, which seem to suggest that people essentially choose to have psychopathological difficulties, are being increasingly called into question (Corsini, 1996).

Self Actualisation

Maslow's notion of a hierarchy of needs, and in particular self actualisation, was a particularly strong influence in Adventure Therapy during the late seventies and early eighties. The wilderness experience can be linked to Maslow's hierarchy in that basic needs (such as food, shelter and warmth) become instantly recognisable once individuals are removed from their everyday environments. Other needs in the hierarchy - safety, belongingness and esteem, can be also be identified as being a key part of wilderness experiences and may be explicitly linked in some programs (Davis-Berman & Berman, 1994). Self

actualisation occurs when one is fully functioning, operating at one's fullest potential, in a way that is unique to the individual. Maslow (1962) believed that few people are fully self actualised but that many people have peak experiences, which are essentially moments of self-actualisation. Despite Maslow's own scepticism about the numbers of people who may be self-actualised, a number of studies were undertaken to ascertain whether those who participated in outdoor programs were more self actualised than those who did not. Not surprisingly in light of Maslow's scepticism, the relationship between wilderness experiences and self actualisation was generally found to be very weak (Young & Crandall, 1984).

Constructivist Perspectives

An increasing number of adventure therapists, reflecting the current popularity of constructivist and information processing perspectives, are suggesting that the processing/transfer elements as opposed to the activities themselves are the essential elements in therapeutic change (Gass, 1993a; Knapp, 1993; Nadler & Luckner, 1992). For instance, research by Witman (1993)

suggested that adolescents participating in Adventure Therapy programs value the *process* over the actual content. Adolescents valued the opportunity to take risks or get support from other participants more highly than the activities themselves.

Techniques which focus on the clients individual experience of an activity have been described in the Adventure Therapy literature as *processing (Gass, 1993b).* Processing can occur prior to, during, or after the experience and is typically used to:

A. help individuals focus on or increase their awareness of relevant issues.

B. facilitate awareness or promote change while an experience is occurring.

C. reflect, analyse, describe, or discuss an experience after it is completed.

D. reinforce perceptions of change and promote integration in participants' lives after the experience is completed (Gass, 1993a).

Fundamental to the constructivist perspective is the tenet that humans learn by 'making sense' of what is experienced. Efficient learning is predicated on individuals' active involvement in the learning process and opportunities for interactive communication among other learners (Fosnot, 1989). Those coming from a constructivist viewpoint suppose that individuals are inherently active, self-regulating beings, who act intelligently on their perceived worlds, in contrast to responding passively to their environments (Iran-Nejad, 1990; Neimeyer, 1993; Resnick, 1987). Individuals are thought to be engaged in a constant search for, and construction of, personal meaning. Learning, therefore, is not simply a matter of taking in new information as it exists externally; it is the ongoing construction and reconstruction of new and more complex meanings by the individual. It is a process of interpretation rather than mechanical accumulation. Such a perspective neatly, but not concisely, explains how individuals may have such different experiences within an Adventure Therapy context, some in awe of their own sense of expanded capabilities while others remember only scrapes and blisters. The challenge for the therapist is to facilitate the processing of the experience in

a creative, as opposed to corrective, manner. The need for careful assessment and exploration of the grounds on which clients are 'constructing' is therefore crucial.

The constructivist perspective within psychology has been closely associated with post-modern philosophy and criticism, and as such, the literature is often rather obtuse and complex - making direct therapeutic applications difficult to formulate. The emergence of Narrative Therapy, championed by Michael White (1989) presents a more practically-oriented framework which has direct application to the processing of Adventure Therapy experiences (Fosnot, 1989; Stolz, 1997).

Social scientists such as Bruner(1985) who described a narrative mode of thought, and Sarbin (1986) who proposed *stories* as a root metaphor for the study of human behaviour and conduct, support an interpretive therapeutic method that embraces the use of narrative. A new experience is framed within a personally relevant story which then provides a unit of meaning that stores and permits the retrieval of the new experience. Narrative

structures become the format into which experienced events can be cast in the attempt to make them comprehensible, memorable and shareable (Olson, 1990).

The story-making process is proposed by narrative therapists to be at the centre of the constructive process. In constructing stories, individuals attempt to convey their intentions by selecting incidents and details, arranging time and sequence, and employing a variety of codes and conventions that exist within a cultural context. Consequently, stories are not merely raw data from which to construct interpretations but products of an interpretive process that is shaped both by the wishes of the author and by the requirements of narrative structure (Polkinghorne, 1988).

With regard to the Adventure Therapy process, Luckner & Nadler (1995) suggest that stories are significant in the following ways:

1. The story that is created from the experience determines the meaning given to the experience.

2. The stories determine real effects, and the type, and degree of transfer of the experience.
3. The stories select which aspects of the experience will be highlighted and then given expression.
4. The stories encompass the learning, helping individuals to store the information in memory and generalise to other experiences in the future.

The goal of narrative therapy is to facilitate the construction of new stories within the adventure process while also examining and subsequently constructing new, more positive perspectives of old stories. By becoming aware of the narrative structures that they have been using, clients are able to examine and reflect on the themes they are using to organise their lives and to interpret their own actions and the actions of others.

White (1989) suggests four themes around which questions should be oriented so as to help clients construct new self stories.

1. Responsibility and owning the success - the goal is to internalise, document and codify the unique outcome: How

do you account for this success? When were you first aware of your decision to take this risk?

2. Expand the temporal plane - placing the outcome or success in time by giving it a past and a future: *What sort of training did you do to prepare yourself for this endeavour? What in your past would have predicted that you could achieve the success that you have today?*
3. Increasing descriptions - opening up space for as many alternative stories as possible by including other's viewpoints: *What do you think this success tells me about you? Who in your past would be least surprised that you accomplished such a feat?*
4. Meaning and difference - the goal is to help participants make distinctions in how they will make sense of the learning and apply it. *What does it say about you now that you have done this? What difference will it make to you, knowing that you wrote a new chapter about yourself?*

The four themes suggested by White all have direct relevance to Adventure Therapy in that there is a rich pool of raw material, in

the form of new and challenging experiences in an unfamilar environment. The constructivist perspective presents a new and exciting approach to Adventure Therapy and has been taken up with vigour, particularly in Europe and the United Kingdom (Amesberger, 1997).

Summary of theoretical approaches:

Clearly, there are a considerable number of theoretical approaches to Adventure Therapy. While it is beyond the scope of this work to evaluate the merits of the various theories with regard to Adventure Therapy, some general themes can be identified. The theories which seem to be most enthusiastically embraced are those which do not necessarily depend on 'talking' or 'working through' issues. The 'wilderness ethic' and 'letting the mountains (and activities) speak for themselves' is still a pervasive notion based on the romantic accounts of wilderness. There would seem to be a considerable amount of appropriation of aspects of particular theories without due regard to the integrated nature of some of the theories. With regard to the current work, there is a notable absence of references to the affective component of the

theories within the Adventure Therapy literature. These concerns are consistent with a field of interest that is diverse and evolving. Some indication of that diversity is presented below in a brief outline of program types.

Program Types and Populations

Davis-Berman & Berman (1994) in a list which they describe as less than comprehensive, describe over 300 different Adventure Therapy programs in the United States. Unfortunately, there are no current figures on the number of programs in New Zealand. Briefly described below are the broad categories of programs which are defined essentially in terms of the populations to which they are addressed. A representative program for each category is described. Most examples are based in the United States but New Zealand examples are used where possible.

Delinquency and prison programs

Some of the very first Adventure Therapy programs were aimed at reforming delinquent adolescents and there has been a

considerable amount of research on programs for delinquents (see Roberts, 1989, Wichman,1983, and Mulvey, Arthur, & Reppucci, 1993, for reviews). Adventure Therapy programs seem to be intuitively applicable to delinquents as the intensity of the programs facilitates cooperation, trust, and a redirection of 'machismo' in more positive directions. Concerns about the negative consequences of confining juveniles in institutional settings also prompted the exploration of alternatives to incarceration. Another factor which prompted the interest in Adventure Therapy was the perceived inappropriateness of more traditional 'counselling' for teenagers who resist the stigma associated with 'therapy' and who may not respond to 'talking' cures with therapists to whom they cannot relate (Brown, 1986).

By way of a New Zealand example, Eggleston (1996) reports on a wilderness program, Te Whakapakari Youth Program, based on Great Barrier Island, New Zealand. Originating as a Maori Affairs initiative in 1977, Te Whakapakari brings together youth of many different cultures (although the majority are Maori) to live together in a wilderness situation, under a Maori kaupapa, for one month.

Participants typically range in age from thirteen to eighteen years, generally have gang affiliations, problems concerning sexual, physical, and mental abuse, and most have problems relating to drug abuse and dependence. Each day is spent gathering food, maintaining accommodation, learning technical outdoor skills, and developing cultural knowledge. The goals of the program are:

1. To provide an alternative to institutionalisation.
2. To develop a positive and supportive whanau during each camp.
3. To develop self-esteem.
4. To replace negative peer pressure with support and assertiveness training.
5. To offer participants the opportunity of developing constructive, trusting relationships with adults and peers.
6. To introduce anger management techniques
7. To develop participants respect for the rights of others.
8. To provide a retreat.
9. To develop Maoritanga.
10. To discontinue drug use.

As can be seen from the goals, there are elements of a number of the theoretical perspectives in the Te Whakapakari program. The program has much in common with programs for delinquents in other countries, while the cultural component separates it out from the majority of programs.

Programs within prisons are typically instituted in order to reduce re-offending. The offender rehabilitation literature indicates that those prisoners who participate on Adventure Therapy programs have a lower rate of recidivism that those who do not participate in such programs. In New Zealand, McLaren (1992) reported average recidivism rates of 10-30 percent post outdoor-program compared to 30-90percent of matched no-program controls.

In general, programs for offenders and particularly for delinquent offenders, are a last resort for those who have not responded to other interventions to reduce offending. The programs tend to be particularly demanding, with a high degree of physical challenge, and typically involve extended wilderness experiences (Davis-Berman & Berman, 1994).

Mental health programs

Adventure Therapy style interventions for those with psychiatric disabilities are not a new phenomena. The 'tent therapy' movement in the United States began around the turn of the century, firstly with patients suffering from tuberculosis and then with nontubucular psychiatric patients. It is interesting to note that the original reason for instituting the program was a chronic lack of space in Manhatten State Hospital. Due to the apparent successes of the Manhattan program[5], other tent therapy programs sprung up. In a series of letters, brief reports, and notes to the *American Journal of Insanity,* various physicians reported on positive results for their patients. A patient of Bloomindale State Hospital reported that "[the program] part of the summer of 1915 was the beginning of my improvement, and we all felt that it was the lift we otherwise would not have had" (*American Journal of Insanity, 73*, 1916, p.334, cited in Davis-Berman & Berman, 1994). These programs were predicated on the supposed therapeutic

[5] 'Program' in the context is perhaps a misnomer. Apart from the location and increased freedom to move around there were no particualar activities undertaken.

influence of 'fresh air' and although most were on hospital grounds there seems to have been an element of escape for patients from an otherwise oppressive environment. Despite the apparent efficacy of 'tent therapy' in a time when there was little to offer patients suffering from psychiatric difficulties, these programs disappeared abruptly around 1920.

It was in the 1960s that 'camping[6]' re-emerged as a possible adjunct to treatment for psychiatric patients. In 1966, Maxwell, Weisman, Mann, & Barker published a report on a therapeutic camping program in the *American Journal of Psychiatry* entitled "Camping: An approach to releasing human potential in chronic mental patients".

This article was significant for a number of reasons. Firstly, it was published in the premier American professional psychiatric journal, indicating that it was being presented for serious consideration by the psychiatric community as a treatment approach. Secondly, there was a sharp focus on the detrimental effects that long-term

[6] The majority of these camps were semi-permanent, often with buildings for cooking, washing etc but with tents and stretchers for patients.

hospitalisation could have on patients, specifically the disempowerment engendered by highly-structured, authoritarian, and isolating hospital environments. These 'camping' programs were typically aimed at chronic (hospitalised for at least two years) schizophrenic patients for whom there was little in the way of treatment in the 1960s. Thirdly, there was an emphasis on the importance of the communal aspects of the program. As far as was possible, all signs of hospital authority were removed, with staff eating the same food which they cooked with the patients, sleeping in camp with the patients, and generally maintaining the same schedules as the patients. Lastly, there was no formal therapy undertaken. Patients were able to choose to engage in a range of activities including fishing, hiking, swimming, as well as contributing to the day-to-day running of the camp. The only 'therapy' involved camp meetings to discuss what people had done during the day and what they wished to do next. The authors reported that of the 90 long-term patients involved in the program, 41 were able to be discharged from the hospital, a remarkable

result in the days when the 'treatment' for schizophrenia[7] consisted largely of palliative care.

These camping programs were clearly the forerunners of the Adventure Therapy programs available today. Pawlowski & Hafner (1993) list the main aims of the majority of Adventure Therapy programs for psychiatric patients and maintain that they are generally designed to allow patients to:

1. Test their cognitive, affective, and behavioural capacities in a normal environment that is free of habitual associations.
2. Develop their interpersonal and problem solving skills in the context of goal-oriented group activities.
3. Experience a sense of achievement, mastery and enhanced competence and self-esteem
4. Acquire a sense of trust in others.
5. Develop strong positive associations with the natural environment.

[7] It is interesting to note that when outcomes are evaluated by disorder, schizophrenic patients seem to benifit from Adventure Therapy programs more than do patients with other disorders. The most commonly noted disorder-related improvements are reductions in paranoia and psychoticism (Shearer, 1985).

From the aims described above it is apparent that Adventure Therapy, rather than being aimed at treating the specific symptoms of a diagnosed disorder, is generally concerned with addressing the diffuse disabilities that may result from a psychiatric disorder. There is however often a degree of overlap. The possible exception to this approach of treating the more diffuse aspects of psychiatric disorders are programs which are explicitly aimed at treating clients with alcohol and substance abuse problems (Gillis & Simpson, 1993).[8]

It is also worth pointing out at this stage that some programs, such as those aimed at drug and alcohol problems, do conduct particular types of psychotherapy (Cognitive Behavioural Therapy for instance) aimed at treating specific disorders, but in a wilderness environment. Such programs are, however, the exception, while many programs include what is loosely described as 'group psychotherapy', most do not include disorder-specific psychotherapies. This topic will be taken up in later chapters with specific regard to the place of emotion within particular

[8] There is however ongoing debate regarding the classification of addictive behaviours (see Wakefield,1992 for a review of the concept of mental disorder).

psychotherapies and the use of such therapeutic paradigms in wilderness or adventurous settings.

Health care programs

Although not especially common, programs targeted for those with physical disabilities or chronic health problems, are becoming increasingly popular (Davis-Berman & Berman, 1994). In New Zealand, organisations such as Outward Bound, Kiwiable, and Parafed, are examples of organisations that provide outdoor programs for this population. Clients facing disease or disability are placed in environments where new ways of responding and coping are required.

Kessell, Resnick, & Blum (1985) describe a program for chronically ill and disabled youth called *Adventure Etc* which is run in conjunction with the Minnesota Outward Bound school. In addition to wilderness/adventure activities such as rockclimbing and canoeing, an urban adventure component is an interesting addition designed to reframe the participants everyday environment in a new and less threatening light. Urban adventures

included bus orienteering and a 'minimarthon'. Significant changes in body-image, increases in internal locus of control, less family conflict, and increases in self-initiated recreational activities were reported. The authors point out that for many chronically ill or disabled adolescents the achievement of age-appropriate developmental tasks is often hampered by a variety of factors such as the reinforcement of a catastrophized self-concept by well-intentioned parents, teachers, and health professionals. Undertaking wilderness/adventure programs is suggested as a way of addressing such difficulties.

School, executive, and 'enrichment' programs:

While they do not easily fall under the 'therapy' umbrella there are three other types of programs that merit brief mention - school programs, 'enrichment' programs, and executive programs. With regard to school programs, it is difficult to ignore the Project Adventure organisation that has been at the forefront of what is commonly called 'experiential education'. Project Adventure is based around action-oriented experiences on what are called 'challenge ropes courses' (Rohnke, 1989). The

ropes courses offer participants tasks of increasing difficulty plus specific exercises that require group participation to achieve a common goal. Other outdoor and wilderness experiences are also often incorporated into Project Adventure courses. 'Processing' is a key term for Project Adventure and broadly refers to participants reflecting and sharing their experiences with other group members. Although this is a key component of virtually all Adventure Therapy programs Project Adventure have operationalised the process and have developed a large number of specific techniques to facilitate this process (Project Adventure, 1991).

'Enrichment programs' covers a broad spectrum of programs but it would seem that Outward Bound provides the template around which most other programs are measured. Outward Bound provides a variety of courses, primarily designed for high functioning individuals, all of which use outdoor challenge, physical rigor, and risk-taking as metaphors for real-life experiences. Martin (1997) summerises the Outward Bound approach:

> *Difficult goals are set, action and experience takes place, feedback is given and performance is reviewed, then new plans are made for improved performance. Peer feedback provides honest observations to heighten personal awareness. The dynamics of the group based experience are fundamental in the development of self perception and influence each individuals personal development (1997:148).*

It has been suggested (Marsh, Richards, & Barnes,1986) that Outward Bound has a 'stocktake' effect on many of its participants, causing them to examine aspects of their occupations, relationships, lifestyle, and aspirations. While most participants on standard Outward Bound courses report changes such as improvements in self-confidence and motivation, it is interesting to note that participants may also report feelings of dislocation and alienation upon returning to their everyday worlds (Mitchell & Mitchell, 1988). Enrichment programs, such as those provided by Outward Bound, are distinguished essentially by their clientele who do not generally have a specific therapeutic goal in mind.

Business Programs

During the 1980s there was a proliferation of outdoor programs specifically targeted (or marketed) at the business world. These

programs have become popular adjuncts to the team building and leadership training retreats that have become part of corporate culture. In New Zealand, The Sir Edmund Hilary Outdoor Pursuits Centre runs programs which use outdoor activities to facilitate team building and managerial leadership development. For many outdoors centers, business programs have become an important source of funds.

Summary

Adventure Therapy then, is an area to which a number of theoretical perspectives have been applied and which takes a number of different forms, which are in turn applied to a diverse range of populations. It is not a new approach, having begun almost a hundred years ago, but it is diverse and dynamic. Various practioners have speculated about the efficacious elements of Adventure Therapy programs. While producing plausible explanations that attempt to incorporate sound theoretical principles, there is a nagging lack of 'fit' with regard to what actually happens while hanging from a rope, running down a rapid, or climbing up a mountain. It would seem that the glaring

ommission in the literature is a lack of concern with a fundamental element of the human experience - emotion.

EMOTION

Having introduced Adventure Therapy, an introduction to emotion is also required. Such a task is daunting in that there is a voluminous literature from many different perspectives, both theoretical and empirical, produced by scholars of eminence. The aim of this section is not to summarise all the major theories of emotion, but rather to identify key themes within the literature. With this in mind, Safran & Greenberg (1991) provide a basic framework of thirteen features of emotion that draw on a number of perspectives, including physiological, cognitive, behavioural, and phenomenological conceptions.

A potential danger in adopting what is essentially a 'pick and mix' approach is that the coherence of individual perspectives is necessarily sacrificed - with a concurrent reduction in explanatory power. The delineation of one feature immediately raises any number of "yes, but ..." questions and concerns. However, the goal of this particular work is to make a start on conceptualising the role of emotion in Adventure Therapy. Broad brushstrokes are required to lay down base colours before the specific details can be added through research specific to the field. It is indicative of the current vibrancy in the field of emotion that Safran & Greenberg's 1991 features have required some updating and expansion due to the amount of work that has emerged in the last five years. Besides the thirteen features, both cultural and gender differences are also briefly considered. The features presented below are put forward as signposts rather than hitching posts.

Emotions are adaptive

At the core of much of the theorising and research presented below is the notion that emotion has been wired into the human organism, and that it persists because it contributes to survival. If emotions were not adaptive they would have been eliminated from the repertoire of humans and other animals as part of the evolutionary process.

Interestingly, Darwin, in his 1872 work *The Expression of Emotions in Man and Animals,* maintained that emotional expression has not evolved and that it is not dependent on natural selection but is rather indicative of biological 'old habits' and the particular way in which the nervous system is wired. This is consistent with Darwin's broader goal of placing humans on a continuum with other species. It is important to note, however, that Darwin did not suggest that emotion was not adaptive and that one of the key functions of emotion is to increase the chances of survival through appropriate reactions to emergency events.

As would be expected for seminal but exploratory work, there is ongoing debate as to Darwin's conception of emotion. While some commentators on Darwin, such as Fridlund (1992), maintain that Darwin posited that emotion did not have any communicative function, Izard (1993) contends that Darwin, in his comments regarding the smiles or frowns of a mother to a child, clearly recognised a communicative aspect of emotion that has adaptive

significance. The other adaptive function Izard identified in Darwin's work concerns the regulation of emotional experiences. Suppressing the experience of an emotion weakens the experience of that emotion, while the full expression of an emotion amplifies the emotional experience (ibid,632). For instance, emotional regulation assists in sustaining and intergrating an organisms position within a hierarchy which supports access to the resources needed for personal survival.[1]

While the functionality of emotion is expanded upon below, the key point to be made here is that emotions have persisted because they are adaptive in that they help organisms deal with key survival issues. Plutchik (1993) writes:

> *Emotions may be conceptualised as basic adaptive patterns that can be identified at all phylogenetic levels ... Emotions are the ultraconservative evolutionary behavioural adaptations that have been successful (similar to amino acids, DNA, and genes) in increasing the chances of survival of organisms* (1993:55).

Emotions motivate goal-directed behaviour important to survival

A key function of the emotions is to safeguard and satisfy the goals of the organism. Frijda (1986) posits that underlying most emotions are a number of what he calls *concerns*.[2] Frijda

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[1] Plutchik (1993), following on from earlier work (Plutchik & Landau, 1973), makes an interesting connection between depression and perceived downward mobility within a particular social hierachy.

[2] Frijda, with his reference to *concerns* is following the lead taken by Klinger (1975) who prefered the term to *motive* or *goal* because of the connotations of activity, actual striving, or awareness of a future state to be reached, which, within Frijda's conception of emotion, is inappropriate with regard to the circumstances under which emotion arises.

(1986:336) describes concerns as "dormant demons", maintaining that they are dispositions that remain silent as long as conditions conform to acceptable standards. For instance, general concern for bodily welfare remains dormant until circumstances, falling piano's and so on, provoke the concern. Concerns may also become salient when they signal that there is a satisfaction condition that could potentially be obtained, as in the case of acute desire or lust.

At their most fundamental level, these concerns are hard-wired and are oriented towards basic survival needs such as hunger, procreation and self protection. Other concerns are derivatives of these more fundamental aspects and develop as a result of learning. For example, the goal of maintaining interpersonal relatedness is a hard-wired concern but the standards that develop as to how one should act in terms of social *mores* and conventions are learned. The particular learned manner or *mores* is not hard-wired but the need (goal) for what the standard derives from (maintaining interrelatedness) is a fundamental concern with a biological basis. In terms of Frijda's conception, emotions function to safeguard and satisfy the goals of the overall system, with the result being a greater likelihood for survival.

Emotions provide action disposition information

There is an intrinsic connection between emotion and action. In keeping with their adaptive functions, emotions supply information regarding the readiness of the human organism to act in a certain

way. That emotions are a source of action disposition information is a feature of a number of perspectives on emotion (Bull, 1951; Frijda,1988; Lang, 1983; Leventhal, 1984).

At its most basic level, reference to the often mentioned prototypical safety-danger situation, or 'fight or flight' reaction, clearly indicates that emotions provide readiness information. Anger, therefore, provides information about the preparedness of the organism to aggressively protect itself while fear provides information about readiness to flee. It is important to note that action readiness may exist without being noticeable in behaviour, that there may only be minor signs such as small changes in vocal inflections, or the absence of an expected response (Frijda, Mesquita, Sonnemans, & Goozen, 1991). As Frijda and his colleagues point out, states of action readiness form an important aspect of subjective emotional feeling. They cite examples collected by Davitz (1969) including "I could have killed him", "I felt like I wanted to disappear from view", "I wanted to do something but I didn't know what"[3], and "I felt like crying".

Lang (1988) differentiated two types of action readiness: strategic and tactical. Strategic action readiness refers to serving the broad goals of furthering or countering interaction with the current situation. Changes in action readiness that serve specific forms of furthering or countering interaction, such as flight or opposition,

[3] This particular example is interesting in that states of action readiness generally closely corrospond to felt emotions and vice versa. Frijda, Kuipers, & Terschure (1989) noted that subjects systematically check states of action readiness as elements of their different emotions.

are tactical. While, as Frijda and colleagues (1991) point out, the difference is one of degree rather than kind, the distinction makes understanding non-specific action readiness changes that underlie unspecific emotion labels such as 'excitement' or 'upset' more readily understandable.

Emotions involve discrete expressive-motor patterns

As pointed out above, emotions provide information about the readiness of the system to act in particular ways. The next step along from this are the discrete expressive-motor patterns linked with particular emotions.[4] These expressive motor configurations involve physiological, vocal and postural changes and the most studied of any of the expressive motor patterns, facial expression.[5]

A major contribution to the relationship between expressive-motor patterns and emotion has been made by Leventhal (for example, 1974, 1984). According to Leventhal, human beings come equipped with basic templates for specific core emotional experiences. These coded neural templates do not depend on past learning and provide the basic structure for *both* core emotional experiences and associated expressive-motor behaviours.

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[4] It should be noted that the notion of each emotion having its own action tendancy and physiological activity is not undisputed. For instance, Ortony, Clore, & Collins (1988) suggest, as part of their critique of basic emotions theory, that such a notion is largely untenable.

[5] Although written 25 years ago, Izard's 1973 work *The Face of Emotion* still provides a comprehensive overview of emotion and facial expression.

In contrast to other theorists, such as Izard (1991) and Tomkins (1962) who have argued that emotional experience is necessarily dependent on feedback from expressive-motor behaviour, Leventhal prefers instead to refer to expressive-motor behaviour as being the first aspect of an emotional synthesis hierarchy. Leventhal does, however, refer to an integral link between particular emotions and specific expressive-motor behaviour. The links between these motor configurations (with facial expression[6] being the most commonly described) are present at birth, where they provide cognitively undeveloped infants with their earliest meaning for situational experiences, and persist throughout life as the basic referent for emotional experience. Leventhal maintains that despite the rapid development of cognitive processing resources these basic referents remain largely unchanged.

Emotion is motivational

Emotion not only provides readiness information about the readiness to act in a certain way but also tends to push towards certain types of action. Lazarus (1991) presents an interesting perspective on what he calls the *motivational principle*. Lazarus points out that the notion that positive emotions derive from goal attainment, conditions that facilitate goal attainment, or steady progress towards goal attainment, and conversely, that negative

[6] Leventhal maintains that facial expression is the most important expressive-motor mechanism associated with emotion and that there are three generalisations to be made regarding facial expression: (1) Each emotion is associated with a distinctive facial expression, (2) It is consistent across the life span for all humanity, (3) The linkages between facial expression and emotion are innate and not learned. The adaptive function of the linkage between facial expression and emotion for Leventhal is primarily communicative in that it provides for rapid, non-verbal communication (1986).

emotions derive from goals thwarted, threatened, or delayed has been discussed for at least a millennium.[7]

Lazarus uses the term *motivation* in two particular but interrelated senses: firstly refering to a personality trait and secondly, refering to a reaction to a set of environmental conditions. By personality trait, Lazarus is referring to the way in which adults have relatively stable value and goal hierarchies. When motives are viewed as traits, Lazarus maintains, they are dispositions for goal attainment that will be enlivened when engaged by the appropriate environmental circumstances. That this is a core concept for the understanding of emotion is indicated by Lazarus;

> *There would be no emotion if people did not arrive on the scene of an encounter with a desire, want, wish, need, or goal commitment that could be advanced or thwarted. The stronger or more important the goal, the more intense is the emotion, other things being equal.*(1991:94)

The second sense in which Lazarus uses the term motivation is perhaps more familiar and refers to the actual mobilisation of mental and behavioural effort in a particular encounter to achieve a goal or to prevent its thwarting. Motivation here becomes reactive to the demands, constraints, and resources present in the environment. Because of the environmental component, Lazarus refers to this type of motivation as *transactional.* When a negative

[7] See Gardner, Metcalf, & Beebe-Center (1970) for a historical review of motivation as the basis for emotion.

emotion is generated by harm or a threat, the person is motivated to do something about this negative condition. This, Lazarus states, is the meaning of emotion as a drive (Lazarus,1968).

Emotions organise systemic priorities through their salience

When presented with multiple and possibly conflicting goals, emotions influence decision making in a way that is consistent with the system's priorities. That emotions have a compelling quality that can essentially override other systems of evaluation is called 'control precedence' by Frijda (1988). This control precedence can involve the interruption of other activities, preoccupation, and persistence in the face of obstacles or distracting events (ibid, 1986). The control precedence of an emotion such as anger may mean that long-term goals (perhaps setting a non-violent example) are overridden in favour of attacking in the face of a potential threat. Conversely, passionate feelings of attraction for a potentially unsuitable person may override the studied evaluation of the pros and cons of forming a relationship (Hatfield & Rapson, 1993).

Frijda (1986) maintains that control precedence is probably the key distinguishing mark of emotion. He maintains that there are two features of control precedence that are part of the 'nature' of human and animal organisms. The first feature is that control precedence for a given action, if not actually taking control of action, impatiently waits to do so. Control precedence implies that

rather than just putting an action at the top of a priority list, effort is required to keep it from taking control.

The second feature of control precedence is that it is 'forced' upon the organism by two relevant signals: pleasure and pain. Once again, there is a persistent and insistent quality to these signals and they continue to be noticed as long as an eliciting event continues or a desire is evoked and unsatisfied. In keeping with his rather determinist stance, Frijda maintains that an emotional impulse and its attendant control precedence overwhelms and controls the individual because he or she does not truly want to control. To control would mean that pain would then be sustained or pleasure forgone (1986:472).

Emotional responses are mediated by anticipated interpersonal consequences

Following Frijda (1988) and his generalised emotional law of the 'care for consequence', Safran & Greenberg (1992) refer specifically to the interpersonal consequences of emotion. While, as was pointed out above, emotions have a compelling quality that can override long term goals and 'rational' evaluation, for each emotion there is also an impulse that is cognisant of the consequences of the emotion, with interpersonal consequences being perhaps the most carefully considered. Lazarus (1991) suggests that each emotion has its own *core relational theme*. He writes:

> *A core relational theme is simply the central (hence core) relational harm or benefit in adaptational encounters that underlies each specific kind of emotion ... Each individual emotion or emotion family is defined by a specific core relational theme. When its implications for well being are appraised by the person, each thematic relationship produces an action impulse consistent with the core relational theme and the emotion that flows from it* (1991:121).

The interpersonal consequences of this impulse of evaluation or appraisal has been further elaborated upon, with an explicitly clinical focus, by Muran & Safran (1993). These authors maintain that, considering the work of people such as Bowlby (1973) on attachment, it is apparent that humans are perceptually attuned to detect clues regarding the disintegration of interpersonal relationships and are programmed to respond with anxiety. Anxiety can then become a cue that alerts people to avoid associated experiences and stimulus situations. Conversely, experiences and behaviours that are valued by attachment figures become associated with a sense of interpersonal felt security. As a result of such learning, individuals develop what were described by Sullivan (1953) as "security operations" which can include diverting attention from anxiety-provoking information, controlling the conversation to avoid anxiety-provoking topics, and presenting oneself in a fashion that momentarily raises one's self-esteem.

What is notable about Muran & Safran's extension of an interpersonal care for consequence is their recognition of the potential maladaptiveness of this feature of emotion. While the emotionally signalled and biologically determined goal of maintaining interpersonal relatedness is always operating, the strategies which the individual employs to maintain relatedness may not be appropriate to the present context and may in fact be detrimental to the goal of maintaining relatedness. Furthermore, it is essential to recognise that the individual's goal is not necessarily one of maintaining relatedness to a specific person in a specific interaction but rather one of acting so as to enhance a sense of potential relatedness in an abstract, generalised sense. This is in keeping with Sullivan's (1953) assertion that the audience to which an individual plays is largely an internal one. To extend the theatrical metaphor with regard to emotion, the applause or opprobrium of the audience is communicated by way of emotion.

Emotion is a primary communication system

As Lazarus (1991) points out, social communication is an important adaptational function of emotion that is clearly not restricted to humans. He points out that herd animals must be able to tell when a predator, who may live with the herd, is hunting, and that mating, without signs of receptivity, can be a hazardous undertaking. Frijda (1986) describes *relational activity* as activity that establishes or modifies a relationship by modifying the relationship rather than the environment - emotion is a primary

relational activity, that for humans in particular, who are characterised by high levels of interdependence, is a primary means of communication.

Emotion is a form of meaning

Emotion as a form of meaning within the literature has generally referred to emotional processing as a quick and economical information source. The information provided is condensed and largely unarticulated (Frijda, 1986; Leventhal,1979).

Lazarus (1991) elaborates on meaning with regard to emotion, pointing out that there is more than one way of knowing. Referring firstly to the phenomenological philosophy of Heidegger and Merleau-Ponty, he then describes the way in which his own fingers seem to 'know' where the keys are on a keyboard despite his inability to describe from memory where the keys are. That there can be dissociations between verbal knowledge and task performance[8] of this kind leads logically into a discussion of the possibility of two different systems of appraisal: one conscious, deliberate and under volitional control, the other automatic, unconscious, and uncontrollable. A discussion of the relative merits of theories regarding unconscious versus conscious knowledge is clearly beyond the scope of this work. However, the key point that Lazarus refers to, that there is more than one way of *knowing* and that emotion is clearly a way of knowing, is an

[8] Lazarus refers here to the work of Brewin (1989) on change processes within psychotherapy. In his writing (for example, 1996, 1988), Brewin has often focused on the role of unconscious representations and refers to the use of emotion as a key means of identifying and modifying these representations.

important point which has direct relevance to this discussion and will be taken further.

Schematic emotional memory mediates emotional responding

From birth, individuals begin developing memory codings for events and the emotional responses they evoke. These memory structures, which are elaborated and refined over time, consist of specific expressive motor responses, relevant eliciting stimuli, associated images, and associated autonomic arousal. Muran & Safran (1993) call these memory structures *emotional schemas.*

Lazarus (1991), in line with his relational focus, points out that while the traditional conception of memorial provocation of emotional schemata treats memory as an internal event, it is also important to consider the external factors that prompt the memory.[9] He asserts that the memory of an emotional event is reconstructed differently each time it is activated.[10] He raises two points to explain this reconstruction. Firstly, as is discussed below, Lazarus explains that as we grow older new schemata are always being formed or elaborated upon. Therefore, the reconstruction of the past tends to change. Secondly, the adaptational context within which an emotional memory is activated must be considered. Memories are not random psychological events, the current situation, or some feature of the current situation, triggers

[9] See Christianson (1992) for a research and theoretical overview on emotion and memory.
[10] Discussions of this sort tend to be based on extrapolation and theorising regarding adults memories. Strongman (1996) points out that, while there has been research on early autobiographical memory, mood, and memory in adult subjects, there is a general lack of research from a life-span perspective.

the appropriate memory. Lazarus suggests a number of possible features that could be responsible for the memory, including the emotional response pattern, the personal meanings and psychological situation that has generated the emotion which are similar to an earlier encounter, a fragment or element of the situation (perhaps another persons dress, or tone of voice), or the configuration and interpretive situation of all these elements.[11]

According to Lazarus, it is the *core relational theme* discussed above, which provides a plot or structure to what may initially be a jumble of images or stimuli, that makes remembering emotional experiences easier. The general point Lazarus seems to be making here is that, in contrast to much of the research literature on emotion and memory, it is often useful to think of the relationship between emotion and memory in molar, rather than molecular terms.

Activation of emotion schemata produces emotional experience

Leventhal (1984) hypothesised that the activation of one component of an emotional schema increases the potential for the activation of the entire schema with the result being the subjective experience of the emotion associated with that schematic structure. Lang (1985) maintains that the probability that a

[11] That particualar elements can have markedly different effects on memory is illustrated by Parrott & Sabini (1990). Using standard mood induction procedures, such as verbal and musical induction methods, they found a pattern of mood *congruent* memory which was consistent with earlier research (Blaney, 1986). However, when they used other methods (referring to the weather, succeeding or failing on an examinantion) they found a pattern of mood *incongruent* memory.

particular emotional schema (or 'prototype' in Lang's terminology) will be activated increases as the number of coded schematic features that are matched increases. He also proposes that some schematic features may be more central or critical in this process than others. Lang makes an analogy between computer programs and emotional schemata where, once activated, the schemata provide the organism with information that motivates action.

Emotion schemata are continually elaborated by new experience

As described above, new situations may activate the emotional schemata that most closely approximate the perceived features of the new situation. The event is then processed in terms of the activated schema but at the same time the specific features of the new situation are adding to the schemata so as to arrive at a holistic 'meaning' for this novel event. This 'new' information is then encoded, thereby further expanding and elaborating the emotional schemata.

That emotional schemata, along with other developmentally linked aspects of humanity, should change over the life- span as new information and processing apparatus become available, is generally accepted. However, there is considerable discussion as to how such development should be most profitably conceptualised and studied.[12] For the purposes of the current

[12] See for instance the discussions of Malatesta-Magai, Izard, and Camras (1991), and for an overview of the area Strongman (1996).

work however, the most important point with regard to changes and elaborations of emotional schemata is that there is potential for the development of maladaptive emotional schemata and also for the restructuring of existing schemata.

Cognitive-affective processing provides a rapid but flexible response system

In describing the emotion-action link, it is tempting to think of the expressive-motor component of emotion in terms of a reflex. Reflexes are unconditioned actions that are initiated by closely delineated external or internal stimuli and they have specific functions (Buck, 1991). While there are some similarities, Leventhal & Scherer (1987) point out that emotions, unlike reflexes are subject to further processing before a *final* decision is made.

While the debate between cognition and emotion is taken up below, the point here is to suggest that there is a degree of flexibility involved in emotional responses. For instance, Lazarus (1993) speaks of changing the relational meaning of an emotional response so as to regulate and transform emotion. He provides the example of a partner responding sharply to an innocent inquiry. The partner who had made the inquiry may wish to avoid feeling and displaying the resulting anger with its potentially negative consequences and may instead seek to essentially excuse the sharp response. The grumpy partner may then be reconceptualised as ill, tired, or stressed - calling for an empathic

and nurturing response rather than anger. Lazarus mentions in passing that this may be a healthy, or at least reasonably adaptive, form of repression or denial, defenses which are almost universally described as pathological.

Culture and Gender

As mentioned at the outset, the 'features' approach taken above, while being expedient in terms of the current work, is also problematic in that the features appear relatively straightforward. Such an approach essentially 'irons out' some of the key debates and difficulties that are crucial to maintaining the dynamism and intellectual integrity of the discussion. Presented below are some useful correctives to the apparently reasonable features presented above. Emotion and culture, and emotion and gender are discussed. The purpose of presenting these issues is not to necessarily invalidate the features of emotion presented above but rather to suggest that the space within which this discussion is presented is contestable and that there are multiple locations for orientation within it.

Emotion and culture

Rather than dredge apparent exceptions, or discontinuites, out from within the ethnographic literature, presented briefly below is an anthropological critique of the current psychobiological models of emotion.

As anthropology's colonial roots were challenged by both those who had been constituted as 'other', and by anthropologists increasingly unsatisfied with positivistic science, the reflexive approach, with its roots in literary criticism, focused attention on the taken-for-granted and power-infused nature of many theories and models. With specific regard to emotion, White (1993), following Geertz (1973), points out that the dominant psychobiological models of emotion are supported by their 'fit' with Western commonsense models, which are dualistic in nature. White lists a number of such dualisms:

mind - body
cognition - affect
thinking - feeling
reason - emotion
rational - irrational
conscious - unconscious
intentional - unintentional
controlled - uncontrolled

While to read through the list is indeed to realise how compelling the dualisms are (Strongman, 1996), what is also immediately apparent to the Western reader is how well these oppositions 'fit' with their world-view. With specific regard to the study of emotion, it would seem that there is a 'metadualism', that is, that emotion is commonly conceived as being 'inside' the individual as opposed to being 'outside' in the social world. Lutz and White (1986) outline a number of essentially dialectical 'tensions', which shape the way in

which emotion is studied. The key notion within their argument is that it is necessary to reflect on the ways in which the *questions* about emotion are formulated rather than focusing exclusively on the *answers*.

For instance, a core, but generally tacit, feature of the predominant psychobiological models of emotion is the assumption that english terms such as 'sad', 'angry' and 'disgusted' are culturally transparent and universally applicable. While it is debateable that such words have a meaning that does not require some interactional 'panel-beating' before the meaning is agreed upon between members of one society speaking the same language, to uncritically accept the translation of emotional terms from one language to another is to court misunderstanding. As Lutz (1988) and Heider (1991) point out, research has not so far provided any substantial evidence for a universal linguistic pattern for emotion.[13]

While there is no strong support for a universal linguistic 'fit' with regard to emotion terminology (even between cultures for whom English is a shared primary language) this appears to have been the assumption of a number of medical sociologists attempting to work across cultures. For example, Kleinman (1985) describes the work of Leff (1973) as an example of a 'category fallacy'. Leff took the Present State Examination, and in keeping with standard sociological methodology, administered it to a large number of

[13] c/f Mesquita & Frijda, (1992) for a discussion of emotion taxonomies utilising a cognitive model of emotion.

English speaking Black Americans. His analysis found less differentiation between individuals' responses, leading to the conclusion that his respondents were less psychologically sophisticated. As Lutz (1985, 1988) points out, conventional methods of standardising questionnaires by translation and back translation yields some degree of semantic equivalence but does not explore the range and context of affective expression that is particular to that group. While criticising work of nearly 25 years ago may seem somewhat facile, similar approaches are still employed and presented as a means of testing theoretical predictions across cultures.[14]

By reflecting (or 'reflexing') on the world in which the questions regarding emotion come to be asked, the constraints and frameworks utilised become an explicit rather than implicit part of the both the reading and researching of emotion. For example, White (1993) describes what he calls 'dual process models' of emotion. These are models which are characterised by their reference to a number of core emotions that are then modified in some way as they are expressed and translated within the social world. A prime example is Ekman's (1992) model which posits six core pan-cultural affects, recognisable through facial expression, which can be modified according to cultural 'display rules'. Such models can usually be identified by words which refer to emotions being 'filtered', 'screened', 'masked', 'amplified', or 'muted'. While, as White points out, such models are attractive in that they

[14] see for instance, Scherer (1997).

account for cultural variation while preserving the notion of emotional universals amongst humans, they:

> *"systematically privilege the biological in the definition of emotion. The parameters of emotion theory, the interpretation of specific emotions, and the foci for comparative research are all determined importantly by the primacy of core affects."*
> (1993:32)

The anthropologically based critique presented above suggests that when engaged in any type of research it is behoven upon the researcher to consider how the questions they research are formulated.

Emotion and gender

It is interesting to note that it is sociologists and anthropologists who have taken the lead in investigating the relationships between emotion and gender (Shields, 1991). In accordance with the critique presented above, it would seem that by using traditional positivist science, the questions regarding the differences between genders regarding emotion were answered in large part by the methodology rather than by the participants experience.[15]

[15] See, for instance, Stoppard (1989) for a discussion of the ways in which the apparently marked differences in rates of depression between men and women are essentially constructed by the way in which depression is assessed within a cognitive behavioural framework. See also Brown (1992) for a feminist critique of personality disorders which has a particularly interesting discussion regarding the way in which 'distress' is concieved of within the DSM framework.

Considering White's (1993) comment above regarding the systematic privileging of the biological in the study of emotion, it is interesting to note a tendency towards a sex-difference[16] explanation framework within much of the research on emotion. As Shields (1991) points out, the sex difference model typically assesses quantitative differences between male and female subjects in a closely defined setting. When a statistically significant difference is identified, there is a marked tendency to attribute the difference to a biologically based (that is, sex-based), stable, fixed, and enduring trait. Brody & Hall (1993), summarising the thoughts of many other authors, observe that efforts to ascribe generalised qualities to males and females are generally theoretically simplistic and empirically unsound. In an earlier article Brody (1985) noted that gender *per se* was rarely the focus of research but was a part of the methodology. Statistical analysis is generally undertaken to rule out the importance of gender as a causal influence on the experiment's outcome rather than to examine a gender difference (Manstead,1992).

An alternative research strategy is to examine gender and its relationship to emotion as part of a social context. One strand of research along these lines that has proved fruitful is the examination of stereotypes. This line of inquiry is particularly important as gender stereotypes themselves may be crucial in bringing about behaviour which is itself stereotypical (Deaux &

[16] "Sex" is used here to refer to the physical fact of primary and secondary sex characteristics, whereas "gender" refers to cultural and psychological constructs and is understood primarily by personal identification and culturally defined standards of sex-appropriate behaviour (Sheilds, 1991).

Major, 1987). Brody & Hall (1993), in a review of the literature, suggest that the main stereotypes relating to gender are: greater female expressivity, greater expression of sadness and fear by females, and greater expression of anger by males. When they reviewed the research literature they found that these emotional stereotypes were frequently borne out across various types of data.[17] Gender differences in peer and family socialisation patterns matched gender differences in later life with regard to emotional expression, experience, and recognition. Differences in the intensity and frequency of specific emotions across the same domains were also noted. They also noted that females are generally superior to males at both expressing (verbally and facially) and recognising emotion. Brody & Hall noted that the differences that they identified were consistent with differing gender roles for males and females in Western society.

What emerges, once again, from the above discussion is that emotion cannot be considered as only being an *internal* and *personal* phenomena. Furthermore, much of the research that has been carried out has been 'men's work', both literally and methodologically. An example of a step in another direction is the one taken by Crawford, Kippax, Onyx, Gault, and Benton (1992). In their research, these authors make no particular distinction between researcher and researched, both are actively involved in the production of the research through what Strongman (1996)

[17] It should be noted that ethnographic or cross-cultural literature (of which there is an increasing amount) was not included in the review and the conclusions are not, therefore, universally applicable.

describes as a sort of 'collective recursion'. Emerging from this research is knowledge that is enlightening despite its apparent blinding obviousness. An example that has particular relevance to the Adventure Therapy field is the differences in location of emotional experiences for men and women. It would seem that, for women, home is generally linked with the positive emotions whereas outside (and presumably wilderness in particular) is linked with being cold and hostile. Men, on the other hand, generally associate being outside with positive emotional challenges.

Research on emotion and gender that is both theoretically informed and methodologically innovative is important for more than the insights it provides regarding the gendered aspects of emotion. Such research is also useful for the model and corrective it provides for research in other areas of emotion.

Summary

The aim of this chapter has been to introduce the features of emotion that serve as the building blocks for the following chapters. The discussions on culture and gender were included to show not only that the features are not as 'tight' as they may appear but also to quietly suggest that the research methods that may be most fruitful for examining the role of emotion within Adventure Therapy may not be those from within traditional positivist frameworks.

EMOTION AND PSYCHOTHERAPY

A central task of most psychotherapeutic interventions is the elimination, moderation, or reformulation of aversive emotional experience. The primary presenting problem for the majority of clients regardless of their specific disorder is that, in one way or another, they 'feel' bad and their aim within therapy is generally to 'feel' better.

Emotion, at least since Freud, has generally been viewed as central to the therapeutic process. The aim of this section is primarily to survey the various stances taken towards emotion and its role in psychotherapy by the major psychotherapeutic schools. By focusing on psychotherapeutic schools, some accounts have not been included on the basis that they have not, as yet, produced particular therapies but have instead formulated accounts of how particular difficulties have developed (for example, Foa, Steketee, & Rothbaum's (1989) behavioural/cognitive account of post traumatic stress disorder). They have also in some cases been able to advance new reasons as to why particular therapies (especially those that are behaviourally based) might work. The obvious example here is the information processing perspective which, as will be seen below, is becoming increasingly important and seems to be on the cusp of a new approach to psychotherapy.

In general, despite often referring to emotion, very few of the major therapeutic schools present clearly articulated accounts of the role of emotion in the change process. It would seem that psychotherapeutic change has generally been conceptualised in terms of cognition and behaviour alone. It is notable that, until recently, very few of the therapeutic schools have refered to the general theory and research on emotion. A recent notable exception to this trend has been within the cognitive-behavioral paradigm where the traditional emphasis on the primacy of cognition has been questioned. The following chapter will present a number of therapeutic implications based on the features described in the previous chapter and the psychotherapeutic literature presented below. Considered are psychoanalytic, behavioural/cognitive-behavioural, and experiential therapeutic perspectives.

Psychoanalytic Perspectives

There is no one psychoanalytic theory of emotion. Various emphases and developments over time have lead to a rather amorphous conceptualisation of emotion within a broadly psychoanalytic framework. There are, however, a number of themes that emerge from the psychoanalytic tradition. The most notable of these is the central role attributed to the unconscious in the production of emotional experience.

Any discussion of the psychoanalytic approach naturally begins with Freud, whose model of emotion was grounded in his

conceptualisation of psychic energy. Before clearly articulating his drive model, emotion for Freud was almost synonymous with psychic energy. Particular emotions were determined simultaneously by the nature of the event that elicited them and by the cognitive characteristics or personality of the individual. Breuer and Freud (1895), upon discovering the apparent value of emotional discharge (or *abreaction* in the psychoanalytic lexicon), posited that it was the strangulation of affect that was the main cause of hysteria.

Maladaptive thoughts, according to Freud, are maintained by the suppression of emotion. The normal reaction to a traumatic event for Freud was abreaction, whereby individuals are able to 'free' themselves from the painful emotion associated with the memory of the event. It is when this abreactive process is suppressed that the emotion remains bound to the memory of the event, leading to the persistence of pathological ideas which Freud supposed led to neurotic symptoms. Abreaction may occur immediately after the traumatic event, spontaneously some time after it, or it may be brought about in therapy to produce a cathartic effect. While *catharsis* has become associated in the popular imagination with dramatic and massive discharges of emotion, Freud maintained that a cataclysmic reaction was not necessary and that a series of small steps may be involved. These small steps may consist of reviving the problematic emotion in therapy and talking (Freud viewed language as a reasonable substitute for action) through the memories that prompted it.

The 'wish' model of psychic function, articulated in *The Interpretation of Dreams* (1900) signalled a transition from Freud's abreaction model to what was to become the foundation of psychoanalysis, the 'drive' model. The wish model held that 'constancy', or the need to maintain a constant level of psychic energy, was the primary motivational principle. When there was an excess of psychic energy it was discharged in the form of emotion with the object of the discharged emotion being remembered and associated with feelings of satisfaction. Consequently, when the need to discharge psychic energy arises again the individual 'wishes' or attempts to re-instate previous experiences of satisfaction. An interaction between instinctual and environmental forces was responsible for emotional development, with psychic energy providing the impetus for emotion and real-life experience determining the particular character of the emotion.

While the wish model described in *The Interpretation of Dreams* was based in an ideational framework, Freud's drive model placed the emphasis squarely on the role of instinct in determining emotion. Initially, Freud maintained that the sexual and self-preservation instincts were the genesis of all emotions. He later added the death instinct. For Freud, the focus on instinct signalled a shift in his theorising from social to biological determinants. In contrast to his abreactive approach, his theorising based on the drive model was largely unconcerned with the quality of a particular emotional reaction except for its indication of the

presence of an underlying instinctual impulse. Furthermore, the actual object of the instinctual impulse was also de-emphasised. What was important was the individual's ability to maintain a constant level of psychic energy through the discharge of instinctual energy.

It is at this point in Freud's theorising that it becomes increasingly difficult to discern exactly what emotion *is.* Not surprisingly for a clinician, Freud gave particular attention to anxiety. Earlier on, Freud maintained that anxiety was the product of pent-up psychic energy which had essentially 'rotted' within the individual. Later, Freud (1926) conceptualised anxiety as a signal that a dangerous instinctual impulse was about to intrude into consciousness, necessitating the need for the initiation of defenses. Anxiety here becomes part of a process rather than a distinct type of psychic energy. What is clear however, is that anxiety has little or nothing to do with external stimuli but is rather the product of intra-psychic conflict. The primary point is that the key to the emotions (whatever they *are*) and their production is to be found in the unconscious. In light of this, the clear treatment focus for Freud was the need to bring the unconscious instinctual impulses into consciousness. The psychodynamic treatment models that have emerged subsequent to Freud have generally emphasised the discharge, repression, conversion and sublimation of psychic energy (Safran & Greenberg, 1991).

An emotional change process emerging from the psychodynamic tradition that would appear to have particular relevance to the Adventure Therapy field, somewhat by virtue of misunderstandings as to what it entails, is *catharsis.* Catharsis has a long and somewhat chequered history, beginning with Freud's (1926) rejection of it as a primary change mechanism.

While the father of psychoanalysis became sceptical about the value of catharsis, there has nonetheless been an enduring interest in catharsis, particularly in 'nonmainstream' psychotherapy. Reich (1942, 1949) emphasised that the value of cathartic experiences lay in freeing people to express their feelings and not as ends in themselves. His primary interest was not in the catharsis itself, but rather in the defenses that prevent it. Reich became particularly interested in the bodily 'armour' that prevented emotional expression. Therapy in the form of deep breathing, massage and exercises was aimed at increasing arousal levels and thereby facilitating emotional expression. Neo-Reichian approaches, such as Lowen's (1975) bio-energetic model, have also emphasised the role of bodily expression of emotion with Lowen maintaining that individuals must "open up and vent these feelings, for their release makes available the energy necessary to the process of change"(1975:121). Approaches such as primal therapy (Janov, 1970) and re-birthing also have catharsis as a central mechanism of change.

In what is perhaps indicative of a general suspicion of the body that emerged as part of the ordering of Western social science (Foucault, 1970), it is apparent that there has been little attention paid to the role of the body in psychotherapy. With specific regard to the role of emotion in psychotherapy this seems incongruous, particularly in light of the considerable research on facial expression (for example, Izard,1991) and the emerging literature on the relationship between emotion and health (Robinson & Pennebaker, 1991).

Emerging as an offshoot of Reich's character-analytic-vegotherapy, Alexander Lowen's (1975; 1996) Bioenergetic Analysis is a method of psychotherapy that integrates work with the body into the analytic process. The genesis of neurosis, according to Lowen, is in childhood deprivation and trauma, which results in the repression of emotions and impulses.[1] Children are said to learn early on that holding one's breath can suppress painful or frightening feelings and that by restricting the depth of one's breathing, the intensity of feelings can be mitigated. Muscular tension in particular parts of the body are said to be indicative of particular types of neurosis - a tight throat may indicate holding back a desire to cry or scream, tight musculature in the pelvis suggesting repressed sexual urges, tense shoulders represent the inhibition of impulses to strike out, and so on. Lowen maintains that "every chronically tense muscle in the body reflects

[1] This is not an orginal thought of Lowen's (although Lowen sometimes seems to obscure this) and is in fact one of Freud's earliest ideas, one developed before his conflict theory of neurosis.

an inner conflict between an impulse or feeling and the expression of that impulse or feeling" (1996:410). The bodily release of intense emotional expression is explicitly connected with the process of change in psychotherapy.[2]

Similarly based in a psychoanalytic theory of repression is Janov's (1970) Primal Therapy.[3] Primal therapy is based on the notion that the painful experiences of childhood do not disappear once the experience is over but remain as a part of an individual's *physiology.* In therapy, the aim is to achieve, through feeling, an understanding of the process by which memories of early painful events are established and subsequently repressed. In practice, the sign that such an understanding has been achieved is a gut-tearing, infantile and agonised *primal scream.* The intensity of the scream is said to be because the pain of childhood trauma has survived, unchanged and unaffected by time and life events.

Both Lowen's bioenergetic therapy and Janov's primal therapy are interesting in that they propose that, to one degree or another, feelings are controlled, expressed and even stored, somatically. Unfortunately however neither of these approaches offer a clear and comprehensive model to account for the hypothesised relationship between the body and emotional experience.

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[2] In a cautionary note which has an obvious connection to Adventure Therapy, Lowen (1996) points out that increasing a person's energy leads directly to more movement, and therefore more feeling, feelings that may be painful or frightening.

[3] It is worth noting that Arlow (1996) suggests that primal therapy is essentially a caricature of emotional catharis as conceptualised by Freud in his early studies on hysteria and that there is a considerable amount of scepticism about primal therapy as a treatment modality.

While cathartic approaches have been of continuing interest to the general public, perhaps because of their generally dramatic style and folk psychology notion of 'letting it all out', they have been viewed with some scepticism by the mainstream psychotherapy community. This scepticism on the part of the psychotherapeutic community, with its distrust of 'drama' and 'irrational' emotion and folk notions, may be for exactly the same reasons that they appear to have a enduring interest for the general public. Another reason may be the lack of clear empirical validation for such approaches.

Nichols and Zax (1977) surveyed the literature on catharsis in therapy. They found that while some studies (for example, Haggard & Murray, 1942; Ruesch & Prestwood, 1949) were generally positive about the effect of catharsis others (for example, Keet, 1948) did not support catharsis, while others (i.e Grossman, 1952; Weiner, 1955) were equivocal about its usefulness. The relative age of these studies is reflective of both the trends in psychotherapy and perhaps the reluctance of the less mainstream approaches to do research that is recognised by the generally conservative world of academic psychology. What is difficult to represent are the substantial number of anecdotal and case reports which give testimony to the potency of catharsis as a therapeutic technique.

A fundamental problem when attempting to investigate the utility of cathartic approaches is the lack of theoretical cohesiveness and the tendency to aggregate concepts such as 'experiencing' under

the general rubric of catharsis.[4] It becomes apparent that while a considerable amount of emotional experience within (and presumably without) the therapeutic realm can be construed as 'catharsis' what becomes central is the interpretation of that experience. What is happening when catharsis occurs? Is it the unconscious instincts which have been locked up being released, or is it perhaps an individual learning to connect cognitions and felt experiences in a particularly powerful way, as will discussed below?

The psychodynamic paradigm remains influential, particularly in applied clinical settings (Strongman, 1996). The treatment focus that is the corollary of the psychoanalytic perspective - that emotions need to be brought to awareness so as to be examined and transformed - remains as a key element of many psychotherapeutic interventions and is testimony to the power of Freud's thinking.

Experiential Therapy approaches

Conceptualising emotions as neither expressions of instinctual impulses (as was the case for the psychoanalysts), nor as learned responses (as will be seen to be the case for the behaviourists), the humanistic and experiential approaches offered an alternative

[4] Greenburg and Safran (1991), in a synthesis of perspectives on catharsis, suggest that it consists of four component subprocesses: (1) experiencing compassion for the self, (2) completeing interrupted emotion/action sequences, (3) releasing inhibiting muscular tension, and, (4) schematic restructuring. In light of the these processes, it is notable that catharsis is almost invariably considered from the point of view of experiencing negative rather than positive emotions. There does not seem to be a literature from the psychodynamic perspective considering the possibility of catharsis of positive emotions.

perspective. In a way that is strikingly similar to the information processing approaches discussed below, these theorists and thinkers propose that affect is essentially an adaptive control system, providing feedback to the organism about its responses to the environment. Discussed briefly under this general experiential rubric is Rogers' client-centered Therapy.[5]

Client-centered Therapy

As is the case for many psychotherapeutic perspectives, particular words or phrases come to have particular significance. For client-centered therapists, the concept of 'experiencing' is such a word. Basically, 'experiencing' refers to all that is going on within the organism at any particular moment, that is available to awareness (Rogers, 1959). Experience refers to the private world of the individual, where some aspects of experience may be easier to bring into awareness than others. A hypothesised key mechanism of change within the client-centred paradigm is the need for the client to 'experience fully in awareness' so that there can be a more complete and accurate symbolisation of experience. By symbolisation, Rogers was referring to the process by which an individual becomes aware or conscious of an experience. As Raskin & Rogers (1996) point out, there is a tendency to deny

[5] The obvious omission here is Gesalt Therapy (Perls, Hefferline, & Goodman, 1951). In general, the Gesalt approach to emotion is consistent with the Client-centered conceptualisation of emotion providing adaptively useful information to the organism. Perls et al (ibid:409) write; "Far from being obstacles to thought, they [the emotions] are unique deliveries of the state of the organism/environment field and have no substitute; they are the way we become aware of the appropriateness of our concerns: the way the world is for us". Dysfunction was suppossed to occur as a result of emotions being interrupted before they can enter awareness or complete their 'organising' action. There is, however, little in the way of a clearly articulated Gesalt view of the role of emotion in the therapeutic process.

symbolisation to experiences at variance with the concept of self, for instance, people who think of themselves as truthful will tend to resist the symbolisation of an act of lying.

'Feelings' are proposed as a key part of experiencing and consist of a union of emotion and cognition as they are experienced inseparably in the moment (Rogers, 1959). Most client-centred therapists stress 'feelings' as opposed to focusing on what Gendlin (1979) described as 'sheer emotion'. Feelings, then, are a cognitive-affective functional unit, an integration of emotion and meaning. While client-centred therapists may occasionally reflect 'sheer emotions' such as being 'sad' or 'afraid' the general intent is to facilitate a more differentiated sense of sadness, such as 'feeling over the hill', or of fear as feeling 'small and exposed'. Such an approach suggests that, in keeping with the notion of experiencing, the information function of emotion can usually be best accessed through idiosyncratic meanings (Rice & Greenberg, 1991).

The client-centered perspective implies some processing mechanisms that integrate different sorts of information. Awareness of feelings provides the individual with meanings that are able to appreciate experience better than would reason or words alone. Rogers (1959) claimed that individuals are wiser than their intellect alone, suggesting that if individuals are open to experiencing their world in as richer way as possible through feelings, they are more likely to act adaptively. One of the ways in

which this may happen is through a recognition of the intentionality of emotion. In a way that has a flavour of the 'core relational meanings' suggested by Lazarus (1991), Gendlin (1962) points out that people are usually 'angry at' or 'afraid of' someone or something.[6] There is, then, a meaning for the emotion in a context, one that is greater than the experience of the emotion itself.

Behavioural and Cognitive-Behavioural Approaches

Behavioural approaches[7]

In marked contrast to the psychoanalytic perspective, with its emphasis on repressed affect and its role in psychopathology, and to the integrative perspective of the experiential approach, behavioural therapy has focused almost exclusively on the modification or elimination of undesirable affective states. There is a clear change in emphasis in the behaviourally oriented theories from attempts to explain what emotion *per se* is, to an emphasis on learned emotional behaviour that is readily observable and testable (Strongman, 1996).

There are two competing strands of thought that have dominated behavioural theories of emotion. Firstly, there are those who consider the individual as a blank slate who learns emotional responses in relation to contingencies in the environment. The

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[6] See Pascual-Leone (1991) for a discussion of the connection between the classical phenomenlogists such as Husserl and Scheler, and the notion of intentionality.

[7] The approaches considered here are primarily those that have led directly to therapeutic techniques, in most cases the therapist and theorist are one and the same. For a discussion and critique of the more theoretical approaches to emotion see Strongman (1996). For an overview of intellectual trends within the behavioural paradigm see Hayes & Hayes (1992), who discuss the ongoing difficulties that behaviourist approaches have with cognition.

most obvious and radical proponent of this view was Skinner (1971), who proposed that humans had a potentially infinite capacity to learn emotional responses. The second perspective views emotional responses as having their genesis in particular predispositions or propensities, a view exemplified by Rachman (1978). As will be discussed, both perspectives have emphasised the use of exposure and deconditioning techniques to modify emotional responses.

'Drive' theorists, so-called because of their emphasis on the motivating aspects of emotion, focus on the role of emotion in conditioning and learning and are therefore part of the second strand of behavioural thought. Fear and anxiety are the key emotions for the drive theorists because they are considered essential to avoidance learning.

Mowrer (1960), for instance, saw emotions as drives and maintained that four, in particular, were crucial: fear, hope, relief and disappointment, each of which have particular eliciting conditions in the environment. For Mowrer, emotion came to be seen as a central state that was elicited by both learned and unlearned stimuli. Throughout his career, Mowrer maintained an interest in the therapeutic applications of learning theory ranging from his still highly influential work on the treatment of enuresis to areas such as the effect of guilt upon the individual. Izard (1991) describes Mowrer's ideas on the origin of guilt as particularly

interesting and provocative.[8] For Mowrer, guilt (which can occur when the individual is alone and in the absence of the source of punishment) develops as a function of the learning process. Repeated punishment for things considered bad, and rewards for things considered good, leads children to develop a sense of proper and improper behaviour. Mowrer asserts that guilt is a type of fear. This fear arises after performing a previously punished act. Furthermore, Mowrer maintained that individuals, through constitutional or hereditary differences, are variously susceptible to guilt and that the development of guilt is facilitated when the learner feels dependent upon another person who is the source of punishment or discipline.

Dollard & Miller (1950), in what is essentially a learning analysis of the psychoanalytic concept of repression, proposed that fear, rather than unacceptable wishes or wants, is the major cause of neurosis. According to Dollard & Miller problems exist not because of unconscious motives but because people are afraid. They maintained that approach behaviours - either to seek comfort, or to express anger - evoke anxiety because of the cues associated with these behaviours. As anxiety reduction is intrinsically rewarding, any behaviour or activity that reduces the anxiety associated with these cues is reinforced. In an extension of their hypothesis that would have greatly disturbed the classically oriented behaviourists, Dollard & Miller also extended their

[8] See Lewis (1993) for a discussion of the 'self-conscious' emotions; embarassment, pride, shame and guilt.

approach to the avoidance of particular internal phenomena, such as particular thoughts. Dollard & Miller's analysis was a means of explaining apparently self-defeating and irrational behaviour, as such behaviour could be explained as responses that were learned so as to reduce fear. The other particularly attractive aspect of their analysis was that it suggested a key, if not rather obvious, treatment goal - the reduction of fear.

In 1958 a South African psychologist, Joseph Wolpe, presented in his book *Psychotherapy by Reciprocal Inhibition* the results of his application of learning principles to adult neurotic disorders. His work was based on Hull's stimulus response learning theory, Pavlov's conditioning principles, and his own experimental research on fear reduction with cats. It was Wolpe's assertion that within a few months or even weeks, 90 percent of his patients were either "markedly improved" or "cured" that attracted most attention. For Wolpe, anxiety was the causal agent in all neurotic conditions. Anxiety was defined as a persistent response of the autonomic nervous system acquired through classical conditioning where:

> *any neutral stimulus, simple or complex, that happens to make an impact on an individual at about the time that the fear reaction is evoked, acquires the ability to evoke fear. Subsequently, ... there will be a generalisation of fear reactions to stimuli resembling the conditioned stimulus* (Wolpe & Rachman, 1960:145)

Based on his experimental work with cats, Wolpe maintained that anxiety is best eliminated by a process he called *reciprocal*

inhibition. The basic premise of this is that a competing response would inhibit and eventually extinguish anxiety.[9] Perhaps the best known and most widely applied of Wolpe's techniques is *systematic desensitisation* (Wolpe, 1969), which works towards decreasing an individual's sensitivity to the objects or situations which precipitate fear. Very briefly, the technique combines relaxation procedures with a graded and repeated presentation of the feared stimuli.[10] The client is taught how to systematically relax the muscles of the neck, face[11], and body. Once the individual can relax, a list of feared situations is composed and then graded from the most to the least-feared stimuli. While relaxed, the client imagines the least feared of the stimuli. This is repeated until the client can imagine the stimuli while remaining relaxed. This is then repeated for stimuli further up the list of fears. The other competing response most commonly employed is assertion, which is taught in a number of different ways.[12]

Subsequent to his work with Wolpe, Rachman (1978) concluded that simple conditioning theories of fear were unable to comprehensively account for the genesis and maintenance of fear. Rachman suggested that only major fears, generally with some

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[9] It is worth noting that Wolpe's formulation and therapeutic techniques were very similar to those put forward by Salter (1949).

[10] For a detailed discussion (including the pitfalls of this approach) and description of procedures see Andrews et.al (1994).

[11] Strongman (1996) notes that behaviourally oriented theorists and therapists have almost completely ignored the substanial literature on facial expression. Izard (1971), one of the authorities on facial expression, presents a fear-reduction technique that seems similar to Wolpe's notion of reciprocal inhibition but which is based on the premise that one emotion can be elimiated by invoking another emotion. Izard maintains that if an individual who feels frightened can engage in the expressive behaviour and thought imagery associated with another emotion (perhaps anger) the fear will subside.

[12] See Lange & Jakubowski (1976) for an overview and introduction to assertiveness training.

biological significance, were likely to be acquired via a conditioning process. That classical conditioning and stimulus-response models were not the only means of acquiring fears was demonstrated through the work of people such as Bandura (1971) who showed that fears could be acquired through indirect processes such as vicarious learning and the provision of information.

Before considering the Cognitive-behavioral framework it is worth briefly outlining the other major treatment techniques that have emerged from the behavioural tradition. These are implosive therapy, flooding and modelling, which in addition to systematic desensitisation (described above) represent the most commonly employed behavioural treatment modalities.

Implosive therapy (Stampfl, 1967) involves repeated imaginal exposure to fears which are, according to Stampfl, precipitated by pairing of neutral stimuli with psychodynamically conceptualised childhood conflict and trauma. Flooding (Sherry & Levine, 1980) is technically similar to implosive therapy except that it involves the actual presentation of the feared stimuli or situation. Both flooding and implosive therapies are supposed to work by preventing avoidance behaviour resulting in the extinguishing or habituating of the anxiety response. Both flooding and implosive therapy expose the client to considerable amounts of fear and anxiety and the ethical considerations involved in such a process are

increasingly being questioned (Wislon,1995).[13] In modelling (Denny, Sullivan, & Thiry, 1977) the therapist demonstrates approach and contact with the feared object and subsequently encourages the client to do likewise. The modelled exposure tasks are presented in a graduated manner. These therapeutic approaches, not surprisingly, have proven most effective when there is a clear feared object rather than more diffuse anxieties.

Behavioural theories are almost beguiling in their simplicity and their approaches to treatment are essentially quite similar. Safran & Greenberg sum up the behavioural approach:

> *Reduction of fear and anxiety has been the major focus, and this focus has governed the way in which emotion is addressed. The overall implication of the various behavioural approaches regarding the role of emotion in change is that certain maladaptive behaviours or habits have been learned as a way of reducing the anxiety elicited by a particular set of cues. Exposure to the feared stimulus without harmful consequences leads to extinction of the fear* (1987:40).

Goldfried & Castonguay (1993) suggest that behaviour therapy has a number of what they call "limiting strengths" which include: (1) attention to fine grained analysis of individuals reactions to specific situations, (2) a dedication to the development and study of specific effective techniques, (3) a skill training orientation to therapy, (4) a focus on the client's current life situation, (5) the encouragement of psychotherapy outcome research and (6) the provision of various forms of intervention to reduce specific

[13] There is a clear connection here to the Adventure Therapy paradigm where, as was pointed out in Chapter 1, there may often be a considerable amount of fear invoked in the course of particular activities.

symptomatology. These authors maintain that each of these apparent strengths also highlight the limitations of behaviour therapy. This is in keeping with Strongman's (1996) assertion that behavioural theories do not go far enough, particularly with regard to the everyday subjective experience of emotion. The limitations of behavioural therapy that have come to light have generally done so as therapists have attempted to apply the conceptual and empirical strengths of behaviourism to clinical practise.

Cognitive-behavioural Therapies (CBT)[14]

Gluhoski (1994) proposes that it is a common misconception about CBT that therapists coming from this perspective are interested only in distorted or irrational cognition and that they view emotion as only minimally important. As a corrective to this, he points out that Beck, the founder of Cognitive Therapy, has from early on, emphasised the necessity of arousing affect in therapy. Beck argued that efficacy is largely due to the client's ability to "experience and express feelings during the therapy session" (Beck et al. 1979:40). Safran & Greenberg (1987) suggest that, historically, the central unifying theme in cognitive-behavioural therapies has been the conceptualisation of emotion as a post-cognitive phenomenon. It is the discussion of this point, within the psychotherapeutic framework of mood disorders[15], that

[14] Some terminological confusion can arise when considering cognitive behaviour therapies and attempting to distinguish between a general approach (CBT) and a specific therapeutic school from within that general approach (such as Beck's Cognitive Therapy, or Ellis's Rational Emotive Therapy). The view taken here, in keeping with Dobson (1988) is that CBT is an approach, not a therapeutic school.

[15] For an overview of the emotion-cognition debate within the theoretical literature see Strongman (1996).

forms the basis of this discussion of cognitive behavioural therapies.[16]

Cognitive-behavioural approaches to the treatment of emotional disorders largely assume that emotional responses are mediated through the interpretations or meanings that are attributed to experience. This idea appears at first to be relatively straightforward and has been a powerful heuristic for the development of effective treatment strategies. However, as Teasdale (1997) points out, what has become clear is that this basic idea has required considerable elaboration and qualification. For some (for example, Leventhal & Scherer,1987; Parrott & Sabini 1989) the whole idea of the primacy of either cognition or emotion is one that would be best abandoned in favour of an analysis based on what could be called a multicomponent processing system that privileges neither cognition nor emotion.

There are a number of factors which have prompted a reconsideration of the cognitive-behavioural insistence on the primacy of cognition. While certain types of cognition may be the antecedents to emotional states, there is also a need to recognise that these same cognitions may be powerfully influenced by affective state to the extent that they may in fact be considered as a consequence of emotional state. The work of researchers such as Blaney (1986) and Morris (1989) with depressed individuals

[16] For a more general discussion of the contribution cognitive science has to make with regard to an understanding of emotional disorders see Watts (1992).

demonstrates that the cognitive interpretation and evaluation of experience can be substantially influenced by a depressed mood.[17] In a related vein, the patterns of negative thinking that are characteristic of depression almost invariably disappear when a course of medication, with no attempt to modify cognitions, is successful in lifting the mood of the individual (Schatzberg,1995).

Teasdale (1997), following Bower (1981,1983), suggests a possible way around such difficulties by positing a *reciprocal* relationship between cognition and emotion. Certain types of interpretation are antecedents to emotional states but, by the same token, these emotional states themselves increase the likelihood of those very same cognitions. There are, however, a number of important qualifications to be made here, and although there is a considerable amount of empirical support for such a view, Singer & Salovey (1988) propose that this support is not straightforward.

Qualifications of such a view include: (1) Apparently similar mood states can have quite different effects on cognitive processing, as is suggested by the work of Parrott & Sabini (1990) on mood *incongruent* memory. (2) Apparently related cognitions can have quite different effects on emotion. It would seem that there is a need for accounts that allow for multiple levels of cognitive representation of each topic, each with particular relationships to

[17] See Fridja (1993) for a discussion on the distinctions between moods, emotion episodes, and emotions.

emotion (Leventhal,1984; Johnson & Multhaup, 1992). (3)The distinction between mood states and cognition may not be clear-cut as is supposed by people such as Beck who propose that cognition is "any ideation with verbal or pictorial content" (Beck et al 1979:12) or that "cognitions are stream-of-consciousness or automatic thoughts that tend to be in an individual's awareness" (Beck, Epstein, & Harrison, 1983:2).[18] At the other end of the spectrum from such views is the perspective of people such as Laird (1989) who posited that "mood affects memory because feelings are cognitions".

The view taken here is that there are indeed multiple levels of representation and that any analysis needs to go beyond a simple primary/secondary or even cognition/emotion point of view in favour of a more systemic approach. Furthermore, it is suggested, in keeping with the anthropological critique outlined in the previous chapter, that such distinctions may be artefacts of the typically binary way in which the questions have been framed. One does, however, need to leap into the circle at some point, inevitably giving the impression of privileging either cognition or emotion.

At this point, the introduction of a heuristic metaphor, which will be expanded upon in a later chapter, seems appropriate. Based on the modularity metaphor of the cognitive neuroscientist Fodor (1983), it is a metaphor first articulated by Ornstein (1992) and

[18] While such an unelaborated and unsophisticated view of cognition probably still holds true for the mainstream of Cognitive therapist's it is only fair to point out that in his most recent writing (for example, 1996) Beck has moved towards a network view very similar to that which is proposed here.

applied by Teasdale (1997) to the conceptualisation of mood disorders, and one which seems to have particular relevance to Adventure Therapy. It refers to the notion of the 'mind-in-place'.

Ornstein illustrates the mind-in-place metaphor by recounting a story told to him by a psychiatrist friend:

> *The psychiatrist had been called by the police to speak with Alfred, a patient of his who was standing on the edge of a cliff, threatening to jump. The psychiatrist ran through with Alfred the implications of jumping: what about the effects on his mother, his children? What about the potential breakthrough he was just about to make at the robotics company where he worked? What about the increasingly real potential of reconciliation with his wife? Alfred had considered all these things already and was resolute in his intention to jump. The psychiatrist walked from the cliff edge, desolate that nothing could break Alfred's resolve.*
>
> *Unaware of the unfolding drama a police officer pulled up at the site, pulled out his loudhailer, and bellowed to the group of people who had gathered: "Who's the idiot who left that Pontiac double-parked out there in the middle of the road? I almost hit it, move it now, whoever you are". Alfred heard the message, stepped back from the cliff, got in his car and parked it properly before quietly getting in the police officer's car and waiting to be taken to hospital.*

As is apparent from the story, the central idea of the mind-in-place metaphor is that we do not have one mind, but many, and that at any one time a particular 'mind' will be dominant, and that this is the 'mind-in-place'. For Alfred, his suicidal intent had been formulated in one mind, one which was replaced by the mind which had another priority, being a law-abiding citizen who obeys the instructions of the police. The basic idea behind the mind-in-place metaphor is that, at any one time, circumstances will call up a particular mind, and this mind then takes center stage, in much the same way as one might access a particular computer program to complete a particular task. As circumstances change, the current mind-in-place becomes irrelevant, and another automatically comes to the fore.

As will be apparent from the discussion presented in Chapter 1, there are some important links here to the constructivist perspective. Although based in part on new research about the nature of emotion, the articulation of a theory of the role of emotion in psychotherapy has not been a major focus of attention. In general, emotions are viewed as informative, in that they reflect the nature of clients' attempts to construct meaning out their of experiences (McGinn & Young, 1996).

THERAPEUTIC IMPLICATIONS

The purpose of this chapter is to firstly present some of the general therapeutic implications of the features discussed in Chapter 2. This is followed by a discussion of the various affective change mechanisms and general therapeutic intervention processes that are suggested by the various psychotherapeutic schools discussed in Chapter 3. While the general structure for this discussion is shaped by the work of Safran & Greenberg (1987; 1989; 1991) and Greenberg (1993) it is also informed by the theoretical critiques of psychotherapy by Lazarus (1991; 1991a) and Izard (1991; 1991a).

Therapeutic implications of the features of emotions- why is emotion important to psychotherapy?

1. The awareness and complete processing of emotion, enhances adaptive functioning.

In that emotion is adaptive, and provides important orienting information to the organism about its situation, to either suppress, ignore or avoid emotional experience suggests that functioning will be less than optimal. If an individual is unable to learn to accurately process one particular type of emotional experience, it would seem to follow that due to the reduction in orienting information and therefore meaning, a maladaptive response is likely to result. For instance, in response to the desire to maintain relatedness within an attachment, relationship an individual with

an anxious attachment style may fail to develop an appropriate response to the action readiness information that anger provides (Collins, 1994). Alternatively, emotional response information may become outmoded as circumstances change, resulting in inappropriate responses. Those with a history of abuse, for instance, may react with anger when feeling that others (with nonabusive intent) attempt to become close (Bricker, Young, & Flanagan, 1993). Furthermore, as Kuhl & Helle (1986) demonstrated concerning depression, the failure to implement an action results in a reduction of processing power as working memory remains 'preoccupied' with a persevering emotional state.[1]

2. Emotion provides both a means of activating and information about schematic structures.

Following on from the mind-in-place metaphor which was introduced in the previous chapter, emotion indicates the presence of a new mind-in-place or affective schematic structure. In keeping with Lang's (1984) proposal that activation of any one component of a schematic structure increases the likelihood of the activation of the whole structure, if a sufficient number of parts are elicited or primed by a therapeutic process, access to a problematic schema is facilitated. This recognises that evocation of emotion is often a non-linear process that may not be best achieved by cognitive means. The research work on the different effects of various mood

[1] See Mathews (1997) for an analysis and critique of information processing biases in emotional disorders.

induction techniques (such as music, the weather or facial expression) also suggests the potential complexity of schematic structures.

As is suggested by Frijda (1986), emotion has a compelling quality that makes it difficult to challenge rationally until further processing makes it possible to make sense of the experience. The implicit meaning for the individual of particular situations, or types of situations, may then be revealed. For instance, a person may experience overwhelming fear in a situation that seems unusual but it is difficult to immediately convince the individual that they don't need to experience fear and it may be equally difficult for the individual to 'talk' him or herself out of being fearful while in the midst of the response until the emotion has been 'run-off'. It then remains to assess the nature of appraisal pattern or mind-in-place that evoked the response.

3. Awareness of elicitors provides personal clarity and control. Following on from the above example, if an emotional reaction or action-tendency occurs without any conscious awareness of the reasons for such a reaction an individual may find themselves puzzled and possibly disturbed by their reaction. Mathews (1997) writes that a commonly heard comment with regard to anxiety disorders is "I know nothing terrible is going to happen, but I can't stop worrying about it". The personal experience of the rapid and generally tacit processing that the information-processing perspective rests on is often neglected. Greenberg (1993) points

out that when there is automatic queuing of an idiosyncratic emotion scheme, which is more self-relevant than situation-relevant, then the response may not seem to fit the situation. Thus people may automatically appraise neutral situations or statements as rejections or as threats to their competence or knowledge; they may feel insecure, anxious, or devalued and unappreciated. Such a situation could also conceivably lead to people feeling angry and frustrated, both with others and themselves.

4. Interaction can be enhanced through an appreciation of the communicative aspect of emotion.

The expression of an emotion is a clear and poignant signal about one's internal state which is never neutral and will rarely go unnoticed (Izard, 1991).[2] For a time during the to late sixties and early seventies (perhaps due to less stringent ethical guidelines to guide research than exist now) there was a considerable amount of research on emotion communication as it related to aggression. Milgram's (1964;1965) controversial studies showed that the aggressive responses made by the unfortunate subjects in response to the request of an 'authority' were influenced markedly by the victim's presence and proximity, conditions conducive to emotional communication. Similarly, a large number of studies showed that eye contact influences behaviour in agonistic

[2] See Pittam & Scherer (1993) for a discussion of verbal expression and the communication of emotion.

encounters.[3] After a period of relative inactivity, there is currently a resurgence in interest in anger and hostility.[4]

Huesmann (1988) suggested that aggressive behaviour in humans is controlled largely by what he called *cognitive scripts*. Scripts relating to aggression in particular are supposed to be particularly resistant to change because aggression is typically immediately reinforced for the aggressor and is therefore likely to be maintained in one's arsenal of strategies for immediate solutions of conflict situations. They are also 'run off' very quickly, due presumably to their core adaptive function. In situations where an individual is not fully processing affective information about his or her own action tendency, others may nevertheless respond to the emotional communication they are receiving,[5] thus eliciting unexpected or undesirable responses in others without understanding what is being responded to. If the action tendency is towards 'fight' rather than 'flight', the unexpected or undesirable consequences may be dramatic as others quickly seek to respond adaptively themselves.

5. The therapeutic relationship is an important medium for both the assessment and modification of emotion.

The therapeutic relationship, variously formulated, is a key aspect of most schools of psychotherapy (Frank, 1979). Traditionally the

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[3] See Pliner, Krames, & Alloway (1975) for an edited overview of studies on nonverbal communication of aggression.
[4] See Lemerise & Dodge (1993) for an overview.
[5] These 'communications', as Kiesler (1986) points out, may be extremely subtle, to the point where people read and react to emotional displays without being completely aware what it is they are responding to.

experiential and psychoanalytic approaches have highlighted the therapeutic relationship. A common misconception regarding cognitive and behavioural therapies is that the therapeutic relationship is undervalued or even irrelevant (Gluhoski, 1994). One of the key notions across a range of schools of thought is that the relationship with the therapist may be similar to how he or she interacts with others (Goldfried & Castonguay, 1993).[6] While specific aspects of the therapeutic relationship will be taken up below, (an often neglected area) the emotions of the therapist, merits attention here. In regard to emotion, the focus, quite appropriately, is on the client. However an important part of that focus, in view of the communicative aspect of emotion, is the emotions of the psychotherapist.

Izard (1991) provides a valuable discussion of the emotions of the psychotherapist and the implications of the therapist's choice of emotion theory. Izard points out that the therapist functions both as a scientifically trained professional with informed basic beliefs about the nature of emotion and as an emotionally responsive person. Therefore, the therapist's own emotions, emotional responsiveness and beliefs about emotion have to be considered along with an intellectual commitment to a formal theory of emotion.[7]

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[6] c/f the psychoanalytic concept of countertransference, see Truant & Lohrenz (1993).
[7] Some commentators (for example, Watts, 1992) would suggest that Izard is being rather flattering to therapists in suggesting that the majority have a clear grasp of, and commitment to, a particular theory or conceptualisation of emotion.

Izard suggests that therapist emotion responses consist of three parts: the emotions experienced, the emotions expressed verbally and nonverbally, and emotion-related behaviour. There is no particular reason to suspect that therapists should not, like everyone else, have different thresholds for emotion activation generally and various thresholds for particular emotions. While the majority of research on individual differences comes from early emotional development, Izard proposes that these are biologically based differences that persist and characterise personality throughout the life-span.[8] Given that these differences exist, the same client may therefore elicit a different emotion or level of emotion in various therapists. Therapist empathy is a crucial part of a therapeutic relationship and is an obvious place where differences in emotional responsiveness may become particularly apparent (Book, 1988; Hoffman, 1981).

Furthermore, like all other humans, therapists may experience emotions but may suppress their experience of them. In some therapeutic schools this is encouraged. Classical analysts are supposed to be a *tabula rosa*, a blank slate upon which the client's concerns are written. In contrast therapists following the client-centred tradition are encouraged to respond in a caring and validating way to the emotions of the client. While it is possible to debate the degree to which it is possible to hide or suppress emotion the important point here is that, as has been discussed,

[8] Such as the work on behavioral inhibition by Kagan and colleagues (1987) and the considerable amount of work on attachment behaviour (see Holmes, 1993 for an overview).

emotions have considerable influence on a variety of cognitive processes, a phenomenon to which therapists are presumably not immune. This has clear implications for shaping the encounter and suggests that assessment strategies in particular, should involve multiple sources of information as is suggested by Lazarus (1991).

6. Emotions are central to the change process in psychotherapy. That emotion is a central but often neglected and misunderstood aspect of therapeutic change is the fundamental premise of the current work. As has been seen from the review of the psychotherapeutic literature above, emotion has traditionally been used as a key source of information for both the therapist and client about the client's world. The other major function of emotion, either through its absence, presence or regulation, is as a marker for change. The notion that emotion is a key mechanism of change, while often being an unelaborated element (particularly of the behaviourally oriented therapies), is also a feature of most therapeutic paradigms. It would be a mistake, however, to suggest that emotion is the only mechanism of change. What seems to be emerging is a consensus that to depend on the modification of only one aspect of the client's world is to predict changes that will be largely superficial, if indeed they occur at all. This has become increasingly apparent with regard to what might be called the 'cookbook' approach[9] to cognitive therapy which has tended to focus on the techniques and procedures by which particular cognitions are thought to be modified.

[9] c/f Kiesler (1994) for a discussion of the merits of standardized intervention procedures.

Meichenbaum & Cameron (1983), following Wachtel (1977), recognised that changes in cognition without the simultaneous involvement of motivation, emotion and action are likely to be minor, short-lived and shallow. Cognitive therapists are often charged with being concerned only with distorted thinking and being largely unconcerned with emotion, viewing it as essentially epiphenomenal (Gluhoski, 1994). This seems unfair in that Beck, in his earliest work (1979), emphasised the necessity of arousing affect in therapy and the central role that the client's ability to "experience and express his feelings during the therapy session"(ibid:40) has in the efficacy of cognitive therapy. Debates about the primacy of cognition or emotion aside, the presence of emotion signals the presence of an important thought and emotions are a potent signal of cognitive shifts. In a review of the Beckian cognitive paradigm Weishaar (1993) points out that thoughts which are associated with a strong emotional reaction are the best representatives of core beliefs and assumptions.

Lazarus (1991) maintains that successful therapy depends on what he calls the *interpenetration* of cognitive, motivational and emotional activities - all focused on actions which are directed at the environment in which the person lives. Therapy should not depend only on one construct, be it cognitive, motivational, emotion, action or the environmental conditions faced by the patient. For instance, even the behaviourally oriented Foa & Kozak (1986) maintain that people must *learn* from exposure to feared

stimuli that their *expectations* are wrong, that they must stop avoiding the sources of their fear and act in ways that make this confrontation possible. Lazarus suggests that there has been an increased spirit of cooperation and appreciation between therapeutic schools. There is an apparent increased appreciation not only of the contributions of other therapeutic approaches but, in keeping with a theme of the current work, that research from academic psychology can provide valuable input into the conceptualisation and treatment of various disorders and difficulties.

Change processes

In light of this rapprochement between therapeutic schools, presented below a brief description of some purported change processes that are thought to underlie therapeutic change. The aim of presenting these representative change processes is to present a broad spectrum of the ways in which emotion may contribute to change, as have been presented by various psychotherapeutic approaches. The emphasis here is to start making links from these processes to emotion theory and research rather than relying exclusively the therapeutic theorising.

Catharsis

The controversial and chequered history of catharsis has already been alluded to above but the enduring general interest in cathartic techniques and testimonials from therapists suggest that

it may well be a change process that is worthy of careful scrutiny. Catharsis is also an important change process to examine because it can tend to become a catch-all phrase for any affective change process that involves emotional expression.

Frijda (1986), in the context of a discussion of response suppression as a means of abolishing or weakening an action tendency, points out that it is important to consider what is being spoken of when catharsis is proposed as a mechanism of change. Frijda maintains that while response suppression engenders tenseness and discomfort, 'letting go' of control is felt as relief and release, a purging of pent-up or blocked emotion. This is the essence of catharsis as proposed by Breuer and Freud (1895). After briefly considering the very weak experimental evidence for a cathartic effect, Frijda suggests that a careful distinction must be made between the short-term effects of releasing control and the long-term therapeutic effects that are proposed by proponents of cathartic experiences. The short term effect of releasing control, according to Frijda, is concerned mainly with getting rid of excitement and preoccupation. However effects of releasing control can vary according to the emotion concerned and to the conditions that exist when the emotion is expressed.

Releasing control of anger, for instance, can lead to an escalation, or to reinforcement of the desire to hurt. Frijda (ibid: 444) refers to a self-reinforcement cycle that can develop when a constellation of maintaining stimuli, provocation and the occurrence of rewards is

met. Alternatively, anger expressed during a quarrel may 'clear the air'; the other person may understand, modify some behaviour or bolster the angry individual's self esteem. Alternatively, releasing control of grief can mean confrontation with memories or images which may have previously been deflected due to a desire to maintain self-esteem (perhaps not wanting to appear weak or vulnerable) and a completion of the response cycle which will allow the acceptance of a loss. Frijda suggests that it is these types of processes which may contribute to long-term cathartic effect. Catharsis, within Frijda's framework, is not a matter of 'letting off steam' from a boiler overheated by suppressed instinctual impulses but rather a way of perceiving situations in their actuality or in terms of what a situation actually means for the individual and an acceptance of one's own response. He writes:

> *It [catharsis] is ... much more like extinction than tension release. It may be supposed to occur, and to occur only, when such confrontation and acceptance have been warded off in the past and can be effected now: when, in other words, letting go of control can produce, or is accompanied by, cognitive change* (1986:445).

In marked contrast to their earlier (1987) reluctance to discuss catharsis,[10] Safran & Greenberg (1991), after reviewing a number of perspectives on catharsis suggest that it may consist of a

[10] Their reluctance was based on a desire to move away from the catch-all phrase 'catharsis' moving instead towards a more differentiated discussion of affective change processes. They also pointed out, following Yalom (1970), that there had been a tendancy within the literature to 'write off' emotional factors in therapy by refering to catharsis, thereby perpetuating the lack of critical attention to emotion processes in therapy.

number on component subprocesses. They are: (1) experiencing compassion for the self, where the very process of 'letting go' entails a softening in stance towards previously warded off aspects of the self. (2) Completing interrupted emotion/action sequences - in much the same way as suggested by Frijda above. (3) Releasing inhibiting muscular tension in keeping with Reich's notion that the suppression of emotional experience may also involve the suppression of associated expressive-motor behaviours through muscular contraction. This is also consistent with theories of emotion that acknowledge that emotion involves an expressive motor component (i.e Izard, 1991). The suppression of emotion then becomes not an exclusively psychological act, but also a physical one where motor behaviours associated with a particular emotion are suppressed through muscular contraction. (4) Schematic restructuring - intense emotional experience that is related specifically to 'unfinished business' may allow access to affective schematic memories that can then be re-examined, leading to schematic restructuring.

It is apparent that the majority of factors relating to catharsis presented above relate to the completion of interrupted sequences, be they cognitive, emotional or motoric (if such distinctions continue to have merit in terms of being distinct processes). This would suggest that there is the need for some focus to the cathartic experience rather than vague and undifferentiated experience that is perhaps more in keeping with the primal therapy suggest by Janov (1970). An enduring difficulty

regarding assessing the contribution of cathartic experience as an affective change process is that there is a dearth of theoretically informed research that clearly differentiates catharsis from other change processes.

Experiencing

Coming from the person-centred tradition, *experiencing* refers to receiving the impact of sensory and physiological events occurring *in the moment* (Rogers, 1959). Emotion then, is not something to be expelled or discharged as it is in catharsis but rather it is to be *felt* or experienced. The goal of experiencing is not to get rid of the feelings[11] but rather to increase awareness of feelings as orienting information that provides the person with important information about their current situation. While there are parallels with catharsis, particularly in terms of what an observer might see,[12] the emphasis in experiencing is quite different.

'Experiencing' has become an increasingly complex construct within the experiential school.[13] As Rogers' theory became differentiated from the actual practice of client-centred therapy it became increasingly difficult to identify Rogers' practical position on emotion as a means of change (Wexler & Rice, 1974). Gendlin

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[11] It is important to keep in mind here that 'feelings' in the client-centered tradition are defined as a complex cognitive-affective unit composed of emotionally toned experience and its cognisized meaning.

[12] Gendlin (1991:266), an eminent practioner and therorist from the person centered tradition writes, "I have dents in my file cabinet and bashed-in plaster in my wall. I am pleased with both".

[13] See for instance the debate between McGuire (1991) and Gendlin (1991) about the merits of particular goals in experiencing.

developed a less analytically oriented and more phenomenologically oriented approach which emphasised the manner in which individuals attend to, and represent, immediate experience. In a passage which goes some way to explaining the distinction between emotion and experiencing Gendlin (1962) writes:

> *Let us compare "experiencing" with the common term "emotion". We said that "experiencing" is a felt datum, and this word "felt" may suggest that it must be an emotion. Often, some emotion is the most important aspect of some present "this" or experiencing. However, just as often, a client will refer to "this feeling" and when he (sic) comes to conceptualise it later*[14] *it will turn out to be a complex of many meanings (such as "I know what is really at the bottom of it, it's that I feel so inferior in action and people will despise me because ..." and so on at length). It is a directly* ***felt*** *datum that* ***implicitly*** *means a great deal* (1962:243-244 emphasis in original).

Experiencing then, is a complex process that is rich in personal meaning. The emphasis on a number of different meaning sources and structures that interact in particular ways has many parallels with the information processing perspective. It is interesting that while the experiential school no longer has the therapeutic ascendancy, there has been something of a rapprochement between cognitive and experiential therapies as cognitive therapists and theorists seek to broaden their horizons (Kuehlwein & Rosen, 1993). With regard to experiencing as an affective change process, the emphasis here is on the need to be cognisant

[14] c/f the notion of primary, secondary and instrumental emotions (Pascual-Leone, 1991).

of as many possible sources of meaning as possible with emotion as a guiding light towards key areas of concern.

Corrective emotional experience

Franz Alexander (1891-1964), who wrote extensively on the association between specific personality traits and certain psychosomatic aliments, fell out of favour with classical analysts for advocating the use of the *corrective emotional experience*[15] as part of analytic technique (Alexander & French, 1946). In terms of Alexander's analytic thought the relationship between the therapist and client gives the therapist an opportunity to display behaviour different from the destructive or unproductive behaviour of the client's parents. For instance, if the client had excessively authoritarian parents, a friendly, flexible, nonjudgemental, non-authoritarian - but with boundaries clearly delineated - attitude means that the client has the opportunity to experience, adjust to and be led by a new parent figure.

Butler & Strupp (1991) discuss Sullivan's (1953) "theorem of reciprocal emotion" which suggests that, in contrast to Freud's unidirectional model, all human transactions (psychotherapy included) obey certain reciprocal or circular 'laws'. This model predicts that the therapist's response to a client's style will be an important component of the resulting interaction. For instance, constricted or inflexible responses on the part of the client will 'pull' for a complementary response on the part of the therapist.

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[15] c/f Beck's (1996) 'corrective information'.

'Complementary' refers here to a narrowing of the range of responses from the presumably infinite range of possible responses. For instance, while a therapist may wish to treat a client as another reasonable and competent individual, a depressed or helpless stance on the part of a client may 'pull' the therapist towards wanting to nurture, jolly along or to solve a current dilemma, thereby potentially treating the client as dependent and incompetent. Kiesler (1982) suggested that the primary locus for this complementary communication is found in the non-verbal, emotional component of interactions between the therapist and client.

In keeping with information processing perspectives that suggest that when the features of an interaction or environment match a critical configuration of an individual's schema, and theories that focus on emotion as a primary means of communication, it would seem to follow that if a therapist is able to resist this 'pull' and 'disengages' from the cycle, there is an opportunity for the restructuring of the problematic schematic structure or network. By 'getting outside the circle', the therapist can provide information at an experiential level that is at odds with the schematic structure which is typically run off in such circumstances, providing a context within which the schema may be examined and possibly restructured.[16]

[16] Classical analysts may suggest that there is no need to resort to notions such as the corrective emotional experience, prefering instead to refer to the concepts of countertransference on the part of the therapist and transference on the part of the client. The implication of the corrective emotional experience here, however, is that, in contrast to the largely conceptual and reflective process of transference interpretation, it is a forward-moving

In what is perhaps an unconventional interpretation of what the corrective emotional experience involves, it would seem possible to suggest that individuals are able to provide their own corrective emotional experience. If, as theorists such as Lazarus (1991) suggest, emotion provides a form of ongoing appraisal of circumstances, an argument could be made that therapies that involve flooding or sustained exposure to, work by providing schema discrepant information that requires either the creation of new schematic structures or the revision of old ones.

Foa & Kozak (1991) suggest that exposure and response prevention changes fear structures and they speculate that this type of treatment may also address pathological cognitive processes that may underlie erroneous aspects of the structure. By linking such notions with the corrective emotional experience it is possible to envisage the creation of circumstances where an individual is unable to complete their own 'circle'. For instance, once an individual has begun abseiling down a cliff, emotion laden notions of incompetence are presumably constantly challenged as the person proceeds down the rope. If, on top of this experience, a corrective emotional experience of a more conventional kind is added, where the instructor is effusive about the client's achievement (whereas in the past the person may have not been

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process that becomes part of the client's ongoing holistic appraisal of the situation, thereby possibly modifying schema by incorporating information from ongoing experience.

praised or encouraged for their efforts) it is conceivable that there is potential for significant change.

While such elaborations may be taking theoretical ecumenicalism rather too far, a growing number of theorists and therapists have come to consider that the impact of an affectively focused intervention is due largely to the effects of a corrective emotional experience rather than the acquisition of intellectual insight.

Attunement

The role of affect in empathic communication is an area that while receiving considerable attention during the 1960s and 1970s has received only sporadic attention in recent years (Duan & Hill, 1996). The earlier studies were clearly focused on investigating Rogers' hypothesis that therapists' unconditional positive regard, genuineness and empathy were 'necessary and sufficient' for therapeutic change to occur. Truax and his colleagues (Traux & Mitchell, 1971), were at the forefront of this research and, despite a number of challenges to their findings (based mainly around the suggestion that what was being researched was a specific response technique - empathic reflection - a primarily Rogerian therapy technique, rather than empathy *per se*), seemed to show strong relationships between these conditions and positive change. After this surge of interest, empathy seems to have become a taken-for-granted aspect of most therapeutic techniques, where it is conceived of as little more than some sort

of kindly and supportive orientation towards the client (Synder,1992).

However, the recent influence of postmodern thought, particularly evidenced by the constructivist approach to therapy, where a multiplicity of realities is assumed, suggests that empathy should be a central concern for therapists rather than a background factor (Anderson,1990). Empathy then becomes a fundamental way of meeting and knowing another person from a different reality. Empathy, according to this approach, is seen as something that exists between the therapist and client, not within one or the other, and therapy is oriented towards restoring the connection with others rather than re-creating an autonomous, separate and essentially Western 'self'. For instance, coming from a Gestalt perspective, Wheeler (1991) and Yontef (1994) emphasise working at what they call the *contact boundary* between the therapist and client. While keeping in mind the anthropological critique, it seems that a potential meeting place is that of emotional experience.

In their overview of a recent volume examining the construct of empathy, Bohart & Greenberg (1997) suggest there are three basic categories of therapeutic empathy: (1) 'Empathic rapport' refers to a general kindliness, global understanding, and tolerant acceptance of the client's feelings and frame of reference and is most akin to the 'common sense' view of empathy. (2) An 'experience-near understanding of the client's world' involves

trying to grasp the whole of the client's perceived situation. This is most characteristic of the psychodynamic approach where there is a recursive cycle of exploration of the client's experience, both conscious and unconscious, and using this to achieve a differentiated understanding of how the client is experiencing his or her world. (3) Emphasised mainly by the client-centred approach is 'communicative attunement'. The aim here is to share, connect, 'be in the moment with' the client's attempts to understand him or herself, access his or her experience, to shape and conceptualise, and to communicate this to another person. The therapist endeavours to put him or herself in the client's shoes at that moment. It is this third type of empathy which involves the greatest degree of affective attunement.

Developmental researchers (for example, Eisenberg & Miller, 1987) have emphasised the importance of emotion[17] in empathy and the work of Stern (1985) in particular suggests that affective attunement may be central to empathic communication. Furthermore, research in this area suggests that deficiencies in affective attunement are associated with distortions in dyadic interaction and increased conflict in interpersonal interactions (Seifer & Dickstien, 1993) indicating that affective attunement may have therapeutic benefits apart from those associated only with those attributed to a good therapeutic relationship.

[17] c/f Shott's (1979) notion of empathic role taking emotions.

Attunement, as described by the developmental researchers, involves intermodal resonance between parent and infant. For example, if a baby is playing enthusiastically with a toy by banging the pieces together, the infant's parent may express attunement by clapping his or her hands in time with the infant, or making verbal exclamations in a tonal quality that matches the intensity of the child's actions. Research where mothers are instructed to misattune their responses to their infant's affective state showed that the normal interactional sequence was disrupted and it remained disrupted until the mother began to re-attune (Stern, Hofer, Haft, & Dore, 1985). Interpersonal communication, as created by attunement, promotes the recognition of shared feeling states for the infant. But as Stern (1985) points out, the converse is also true - feeling states that are never attuned[18] will not become part of the infant's developing repertoire. Moving into the therapeutic realm, Safran & Greenberg (1991) suggest that affective attunement by the therapist may play a vital role in helping the client to contact, articulate and intergrade into his or her sense of self-adaptive feeling states which are currently unarticulated.

A note on prevention

With the notable exception of Goleman's (1995) focus on the need to enhance the 'emotional intelligence' which has resulted in programs to teach such things as empathy skills, there would

[18] The work of Stern and colleagues (1985) indicated that some mothers consistently misattune to their child's affective experience. This was particularly true for mothers who were ill and a particulalry intriguing finding was that the cultural norm of communicating in 'motherese' was noticelably less apparent in ill mothers.

seem to have been little written about the ways in which primary prevention of pathological emotional problems may be achieved. Lazarus (1991) maintains that thus far the principles involved in primary prevention are so general, and the number of variables so great, that it has tended to rely on what he describes as "pious slogans" rather than clear courses of action (ibid,464). Lazarus points out that we still know little about things such as under what conditions a trauma impairs later adaptation, or what kinds of, and at what stage of development does stress facilitate or impair child's later development.

Secondary prevention concerns efforts to keep an already existing dysfunction from getting worse. It would seem that whether one describes assisting people to cope with difficulties as secondary prevention or therapy is rather academic. Lazarus does, however, suggest that more careful attention needs to be paid to the distinction between what might have traditionally been called neurosis and temporary reactions to severe difficulties of living. He suggests that the tendency to emphasise characterlogical neuroses now seems incomplete and involves essentially blaming the victim of destructive life conditions for not functioning well.

Summary:

A general framework is presented by Greenberg (1993) who suggests that in light of both emotion theory and practice of psychotherapy there are three major types of intervention processes: acknowledging, evoking, and reconstruction of emotion

schemes. In terms of the changes processes described above, acknowledging is analogous to experiencing, attunement and empathy, evoking has most in common with cathartic approaches, and the corrective emotional experience involves reconstruction. These are not, of course, the only possible change processes and Greenberg's framework of acknowledging, evoking, and reconstruction provides a means of conceptualising other specific change process.[19]

Acknowledging essentially involves directing clients towards attending to their emotional experience. This is based on the premise that emotion cannot fully serve its adaptive function if it is not being attended to with accuracy and immediacy. Interventions based on acknowledging emotion essentially fall into two categories. The first is training client's to be aware of different aspects of their experience, including bodily sensations, expressive actions, cognitive-affective complexes (such as feeling 'over the hill') and the like. The second category involves affective attunement and empathically responding to clients' feelings with a view to facilitating the clients' attention to inner experience and acknowledgment of emotion.

Evoking and intensifying emotion leads to various possible change processes. Firstly, as has been discussed, emotional experience leads to the accessing of core schema. Safran & Greenberg

[19] For an overview of other change processes (such as reowning) see Safran & Greenberg (1987).

(1987), drawing on Abelson's (1963) original use of a hot/cold distinction, refer to 'hot cognitions' which involve affectively laden thoughts which have a salience that overrides 'cold' hypothesising or analysis. Secondly, the experience of emotion is linked to an action tendency and is therefore motivational. While this action tendency may be the focus of therapeutic intervention, as can be the case in violent behaviour, in other contexts (perhaps when fear has reduced the capacity for assertive action) the evocation and intensification of anger may be therapeutic. Thirdly, the expression of emotion can lead to further processing and completion of a sequence which may not have been 'run-off'. This seems to be particularly relevant in terms of grief and trauma where there has been incomplete processing of the appropriate emotional reaction along with an interruption in action tendencies. The evocation of and surrender to emotion allows the emotion to 'run its course'.

Emotional restructuring involves techniques which firstly make available the relevant activating information, and then provide novel information from as many sources as possible. It is still a point of conjecture and debate whether old schema are being modified or elaborated or whether new, more adaptive schema are being created. Covering the gamut of therapeutic approaches, Greenberg suggests that restructuring can occur when contradictions are resolved, when new organismic information about needs and concerns becomes available, when adult processing capacity is applied to childhood experience, when greater attentional capacity is made available enabling the

synthesising of more information, and when dysfunctional beliefs in schema are changed.

The particular change processes which have been described above were chosen on the basis of their therapeutic 'heritage' and for their apparent relevance to Adventure Therapy. Whether or not these particular processes prove to be the most applicable will only be confirmed by substantive research. Greenberg's general framework of acknowledging, evoking and restructuring, provides a means within which other change processes may by conceptualised and as such 'makes space' within which other interventions can potentially be included.

COPING AND RISK

The previous chapters have focused on general features and processes that, as will be discussed in detail in Chapter 6, have a connection to Adventure Therapy but which do not focus directly on the activities which are part of the Adventure Therapy approach. Considered below are two aspects which have particular relevance to the activities which participants may engage in as part of Adventure Therapy programs; coping and risk taking. Surprisingly, for processes which are constantly referred to as being part of Adventure Therapy programs, there has been little apparent research attention paid to these aspects. Perhaps as a consequence of this, there has been a tendency in the Adventure Therapy area to assume firstly that these are relatively straightforward processes, and secondly, with specific regard to emotion, that emotion is a hindrance to effective coping and 'rational' risk-taking. The aim of the discussion below is to suggest that this attitude does not adequately take account of the psychological literature and that a more sophisticated approach is required to make effective therapeutic use of adventurous activities.

Coping

Coping is an everyday process. Everyday language is full of coping phrases such as "I managed to deal with it" and its more assertive recent variation, "I dealt *to* it". Folk conceptions of psychopathology often seem predicated with a reference to a lack

of coping - "she/he just wasn't coping". With specific regard to Adventure Therapy, improvements (generally undefined and unmeasured) in what are usually called *coping strategies* are often part of a program's aims.

Coping is also increasingly an area of interest for psychologists from a number of different perspectives.

While the closely related concept of *defenses* has been a theme in therapeutically oriented psychology, at least since Freud, the interest of the psychological community in *stress,* an interest which flowered in the 1960s, logically resulted in a considerable amount of discussion about coping. With specific regard to the study of emotion, especially amongst cognitively oriented theorists and researchers, coping has become an important theme, to the point where it has been conceptualised by some as a subset of emotion (Lazarus, 1996). The aim of this discussion is firstly to briefly outline the major theoretical approaches to coping with a focus on the work of Lazarus and his colleagues. What becomes apparent is that, despite the voluminous amount of theorising and research on coping, it is still a dynamic and developing area. Furthermore, with regard to the Adventure Therapy area, the ways in which participants cope with the activities involved and the process of engaging in the activities is generally seen as a key part of the therapeutic process.

There would appear to be two main approaches to coping: those who are primarily interested in coping *styles* and those whose focus is on the *process* of coping. The coping style approach has its modern roots in the psychoanalytic interest in defenses. Freud, while acknowledging that there were a number of defense mechanisms, was chiefly concerned with repression, which he viewed as the most important and most commonly applied defense. The essential function of the defenses is to protect the individual from emotional distress prompted by awareness of internal or external stresses.

It was Freud's daughter Anna, in her book *The Ego and the Mechanisms of Defense (*1946), who first clearly articulated the psychoanalytic perspective on defenses. Anna Freud maintained that both normal and neurotic individuals had a characteristic and discernible repertoire of defenses. Her oft-quoted observation that "there is depth in the surface" reflected her contention that defenses adumbrated the complexity of the defensive aspects of the ego. Each libidinal phase of development, with its specific drive components, necessarily evoked particular defenses. The anal phase, for instance, is associated with reaction formation (the transformation of an unacceptable impulse into its opposite) due to the development of shame and disgust in relation to anal impulses and pleasures (Inderbitzin, Luke, & James, 1990). Further to this, in a notion that became a touchstone for clinical psychology, and psychiatry particularly, it was proposed that particular forms of defenses were associated with particular forms of

psychopathology (or *neurotic breakthrough* in psychoanalytic parlance). Intellectualisation was associated with obsessive-compulsiveness, paranoia with projection and denial, mania with compensation and sublimation and so on.

The developmental focus of the psychodynamic approach to defenses continued and was explicitly articulated in the work of Menninger (1954) and Hann (1969). Vaillant (1977) began articulating a hierarchical approach to defenses without the same emphasis on classical psychosexual formulations. Vaillant proposes that there are four types of defense mechanisms. Narcissistic defenses (such as denial) are the most primitive and are used by children and psychotically disturbed individuals. Immature defenses (introjection, for instance) are characteristic of adolescents. Neurotic defenses (that is, repression and isolation) are seen in obsessive compulsive and hysterical patients and in adults under stress. Mature defenses (humour and altruism, for example), within Valliants framework at least, are adaptive mechanisms of adult life.

This conception of an adaptive hierarchy of defenses led to the development of a number of trait type measures[1] which endeavoured to objectify what had, until that time, been a primarily impressionistic pursuit based largely on inference. There is a clear link here to trait-based personality research which in the early 1970s was just beginning to capture the imagination of

[1] See Cohen (1987) for a review of these measures.

researchers in the field. The coping style approach, then, is clearly linked to the psychodynamic and ego-psychology movements which are now often considered rather weary theoretically.[2] However, as will be discussed below, there is still a tendency to attempt to apply trait type or dispositional attributes to individual's coping processes. This may be a reflection of the methodological preferences of researchers and clinicians who attempt to make people, as it were, 'hold still'.

Rather than attempting to tie down particular styles of coping, a group of researchers began to consider coping as a *process.* At the forefront of this work for more than 30 years has been Richard Lazarus, who in concert with a number of researchers (particularly Folkman) has developed the process approach to coping. This process approach rejected the dispositional approach of the psychoanalytic and ego-psychology schools.

Lazarus (1993) outlines five principles of the process approach:

1. In marked contrast to the hierarchical approach, Lazarus maintains that coping thoughts and actions should be measured separately from their outcomes. The adaptiveness of a particular way of coping depends not only on the person but on at least three other factors: firstly, adaptiveness depends on the specifics of the situation. Secondly, on the time frame being considered (a way of

[2] Despite the current enthusiasm for cognitive and biological accounts and a concomitant lack of interest in psychodynamic explanations, it is worth noting that DSM-IV includes a Defensive Functioning Scale as a proposed axis for further study. The framework is explicitly hierarchical and has a strong ego-psychology flavour, complete with reference to unconscious processes.

coping may be immediately adaptive but still have long-term negative consequences), and lastly, on the particular type of outcome being considered (for instance, an exercise program may have positive effects on somatic health, but deleterious effects on relationships which are not maintained due to the time taken to exercise).

2. The process of coping employed for any complex stressor will vary according to the adaptational significance of the stressor and the requirements of the stressor. What this means in practice is that it is necessary to identify the particular threats within a complex situation (having a life-threatening illness, for example) which have particular salience for the individual at a particular time.
3. Coping measurement should "describe what a person is thinking and doing in the effort to cope with stressful encounters" (ibid, 236). Lazarus & Folkman (1988) developed the *Ways of Coping Questionnaire,* which was intended to provide a means of examining the process of coping within various contexts rather than as a measure of coping style as it is conceived psychodynamically.[3] However, Lazarus maintains that there are consistencies (and inconsistencies) in coping process both over time and across stressful encounters.
4. Lazarus (1993:237) defines coping as:

> *... ongoing cognitive and behavioural efforts to manage specific external and/or internal demands*

[3] see Coyne & Gottlieb (1996) for a critique of checklist measures of coping, with a particular focus on the *Ways of Coping Questionnaire.* Coyne and Gottlieb suggest that such questionaries are an imposed narrative which is too narrowly focused.

that are appraised as taxing or exceeding the resources of the person.

The key feature of this definition is that there is no reference to the outcomes of the process. The link here is to point number 1, that process should be measured independently from outcome. Lazarus is not, however, expousing an extreme relativist perspective, he is concerned with both the *adaptiveness* (the extent to which coping improves adaptational outcomes such as social functioning or physical health) and with the success (the extent to which the person believes a coping related reappraisal).

5. In what has become perhaps the best known aspect of the process approach, Lazarus maintains that there are two major functions of coping; *emotion-focused* and *problem-focused.* Simply put, emotion-focused coping is concerned with managing emotions rather than the environment that aroused them. Alternately, problem-focused coping is directed towards the conditions that arouse stressful emotions.

The five principles outlined above have resulted in a considerable amount of research and discussion. It is the fifth principle that is of particular interest here, due to its apparent heuristic value. The two functions, at least at first, seem to simplify a complex process. Whether simplification of complex processes is itself a useful endeavour is beyond the scope of this discussion. It would appear,

however, that it is the tendency towards reification of heuristics[4] (such as problem-focused and emotion-focused coping processes) and a general mistrust of emotion as 'sensible' that has resulted in the misapplication of the two functions.

Lazarus himself (1996) has been at pains to address what he sees as misconceptions regarding the problem/emotion-focused functions of coping. Lazarus criticises others, and himself, for a tendency to treat coping functions as action types. The task of measurement almost inevitably leads to the formulation of action typologies so as to distinguish one measured thing from another. However, Lazarus writes:

> *... functions do not refer clearly or consistently to actions; any action can have more than one function. And if one does not know the full context of coping, including what the person is trying to accomplish, the classification is often specious.* (1996:292)

While Lazarus provides a modern example based on the use of beta-blockers to reduce the physical symptoms of performance anxiety that illustrates the futility of creating a binary opposition between problem and emotion focused coping I would like to briefly explore another example:

> *And now my life ebbs away;*
> *days of suffering grip me.*
> *Night pierces my bones:*
> *my gnawing pains never rest.*
> *In his great power God becomes like*

[4] See Dumont (1993) for a selective review of the ways in which heuristics influence clinical problem formulation. The points Dumont makes with regard to clinical work would also seem applicable generally, when researchers attempt to formulate how individuals cope.

clothing to me, he binds me like the
neck of my garment.
He throws me into the mud
and I am reduced to dust and ashes.
Job 30: 16-19[5]

Here then, is Job, an archetypal 'coper' for two major religions.[6] It is when an example such as this is considered that the centrality of context to the coping process is apparent. It is interesting to consider, as a psychologist, the model of coping that is presented by Job and, by extension, other 'religious' ways of coping. Freud himself clearly considered religion as a neurotic form of explanation and defense that belonged to the infancy of humanity, that would, or should be supplanted by the primacy of intelligence (Freud, 1913). Later psychodynamic theorists became more interested in formulating the ways in which religious belief 'worked' for the individual where such beliefs, however unfounded they may appear, could be considered as either highly pathological (when religion was a form of distortion - a narcissistic and infantile defense) or as rather benign (with religious belief promoting altruism and anticipation - mature defenses).

Turning to the process approach, in terms of problem-focused and emotion-focused coping, a religious approach immediately highlights the difficulties involved in, and perhaps the futility of,

[5] New International Translation.
[6] It is interesting to note that there does not appear to be a body of psychological literature that discusses the cultural components of coping, or cross-cultural comparisons of coping.

classifying coping processes in terms of oppositions.[7] For example, the atheistic or agnostic researcher may be compelled to consider religious coping as *emotion-focused*, while the individual doing the coping (by praying or making sacrifices, for instance) may consider such actions to be clearly *problem-focused*. A *both/and* rather than *either/or* approach seems clearly more appropriate in such a case.

Lazarus, with his strong aversion to linking outcome with coping process, and his contention that only observers can assess the 'success' of a coping process, does not seem to deal adequately with the role of expectancy in the coping process. Lazarus does consider *appraisal* as a key part of his general theory of emotion and refers to it with regard to coping (Lazarus, 1991). For Lazarus, appraisals are either *primary* or *secondary*. Primary appraisals involve assessing what is at stake in a given stressful encounter while secondary appraisals involve evaluating the coping resources and options available (Lazarus & Folkman, 1984). Lazarus, however, does not seem particularly interested in the individuals expectation of outcomes as the result of specific responses. Lazarus sometimes (Lazarus, 1993) seems to suggest that individuals set out on the coping process and almost 'play it by ear', adapting the process as they go. While, to a degree, this does seem to be the case, the social cognitive perspective, and particularly the work of Bandura, suggests that individuals may

[7] An interesting background theme to this discussion is the *contestability* of the attribution of pathological and benign - who is best placed to make such attributions and how these attributions are legitimated (for one perspective, see Foucault, 1965).

also have quite specific efficacy expectations which they use to shape the coping process.

Bandura (1988) refers to two types of response outcome expectancies. One is concerned with the outcomes that are likely to result from a specific response. The other is concerned with the degree to which an individual[8] expects to be able to perform a particular response, or *self-efficacy.* Some writers (such as Ursin,1988) go so far as to equate positive response outcome expectancies directly with coping. Bandura (1997) is critical of dichotomous thinking with regard to problem and emotion focused coping. He does not, however, seem to raise any criticisms that Lazarus himself has not pointed out, particularly with regard to the changeability of situations and the confounding of means and ends. That said, there would still appear to be room within the process approach to coping for a more extensive integration of the construct of self-efficacy.

Lazarus, as described at the outset of this discussion, maintains that coping can be usefully considered as a subset of emotion. Lazarus criticises research that separates coping from emotion:

> *... psychologists think of an emotion as one event or process, and coping as another, both separate but presumably connected by learning. This stems from the long tradition in psychology of separating stimulus and response, afferent and efferent, and perception and action (1996:297).*

[8] Bandura (1997) also clearly believes in corporate self-efficacy, as might be found in sports teams, schools, or communities. Such a perspective serves to widen the possibilities with regard to coping research beyond the supposed boundaries of the individual.

Lazarus suggests that this tendency stems from the style of reductionist science which has dominated psychological inquiry. Within this paradigm it is necessary to reduce a phenomena to its basic elements to understand it. Lazarus seems equivocal about the utility of breaking a process into component parts (he did after all develop the Ways of Coping Questionnaire, which does just that) but maintains that psychologists generally ignore the need to resynthesise the elements into a "living system".

Lazarus' key point here with regard to coping and emotion (if indeed it remains appropriate to use the two separate terms) is that:

> *we must abandon the bad habit of thinking of emotion as an event that leads to a coping response, and instead recognise that the emotion process includes coping* (1996:298).

Lazarus (ibid) suggests that it is the personal significance or *core relational theme* that is what takes the emotion process to a higher level of abstraction, with coping contributing to this process by indicating what is possible in a given situation. While the apparently hierarchical notion of 'higher levels of abstraction' seems to muddy the water of integrated 'living systems', it would seem that the *core relational theme*s of emotion provide some type of epistemological substrate.

If there is going to be a 'third generation' (with the psychoanalytic and process approaches constituting the first and second generations respectively) of coping research, what are the key

questions and issues that will shape the research? As pointed out by Coyne & Gottlieb (1996), there are a number of difficulties with the checklist approach to the measurement of coping. Furthermore Stone & Kennedy-More (1992) question the utility of the factor analysis in the analysis of such data.

When to measure coping remains problematical. It is generally inappropriate and may in fact be spurious (in that the process is amended by the act of measuring it) to attempt to measure coping while an individual is involved in the coping process. Most checklists are retrospective and are not specific about what it is that might constitute a 'coping episode'. It would seem that methods which involve recording a coping process (by means of videotape for instance) may provide a way of addressing some of the temporal issues of coping assessment.

The consistency of coping and its relationship to personality is an area ripe for theoretical development.[9] Lazarus (1993) reports that some strategies of coping, analogous to personality, are more stable or consistent than others. Lazarus himself (1993) reports research which suggests that optimism and pessimism influence the way stressful encounters are dealt with. A possible area within which to start the analysis could be from a developmental perspective. As was described above, those from a psychodynamic perspective were explicit about the link between

[9] See Suls, David, & Harvey (1996) for an overview of recent research on coping and personality that uses a trait model of personality. See also Pervin (1993) and Krohne, Hock, & Kohlmann (1992). Another strand of related research concerns the links between personality, emotion, and health, see Robinson & Pennebaker (1991) for a discussion.

defenses and developmental stage. While the psychosexual developmental model has fallen from favour, it would seem that there has not yet been any further attempts to develop a substantial and integrated developmental perspective.[10]

The adaptiveness or effectiveness of certain coping strategies remains a fascinating area but unfortunately coping and outcomes are still often confounded (Stanton et al. 1994). The confounding of coping and outcome has led to an explanation that suggests that emotion-oriented coping is well correlated with emotional distress (presumably an undesirable outcome). With specific regard to Adventure Therapy, consider a climber awash with fear on a difficult climb recognising that his or her fear needs to be coped with as it is standing in the way of addressing the problem at hand. The tendency to devalue emotionally-focused coping, while being historically understandable, needs reassessment. Thus far, the focus has been on how people respond to situations they find themselves in. The other side of this particular coin are the means by which they find themselves in these situations in the first place. In keeping with the Adventure Therapy theme, a key issue is the role of risk-taking, which is an explicit part of most Adventure Therapy programs, and more specifically the role of emotion in risk-taking.

[10] A possible starting point for such an investigation could be the link between coping and attachment. The attachment paradigm (Ainsworth & Bowlby, 1991) would seem to provide, at least intuitively, a means by which particular coping processes might become more or less likely to be utilised. In a similar vein a dispositional perspective has been advanced by Ayers et al (1996).

Emotion and risk-taking

Almost immediately upon attempting to link risk, adventurous activities and emotion, the substantial research tradition within psychology that has looked at situations that involve possible injury or death emerges, a tradition which often explores the possibility of a 'sensation seeking' trait. The word 'trait' naturally alerts the reader to the fact that sensation seeking, as it has come to be commonly conceived of, is considered as an aspect of personality.

To be even more specific, the term has narrowed to be almost synonymous with measures of the Sensation Seeking Scale (Zuckerman, 1978, 1979). What also emerges is a general suspicion of those who might engage in activities which are associated with sensation seeking. Zuckerman, Bushsbaum, & Murphy (1980) summarised the behavioural correlates of sensation seeking (as measured by the Sensation Seeking Scale). High sensation seeking correlated with greater sexual activity, multidrug use, cigarette smoking, volunteering for unusual experiments, participation in physically dangerous activities, and elevations on the Hypomania (Ma) and Psychopathic Deviate (Pd) scales of the Minnesota Multiphasic Personality Inventory. What is particularly apparent, however, when examining the subscales[11]

[11] The subscales are (a) thrill and adventure seeking, which measures the desire to engage in physically adventurous activities, (b) experience seeking, which measures a desire for experiential variety through a non-conforming lifestyle (as in joining 'counterculture' groups), (c) disinhibition, which measures traditional nonconformity through release and social

on the Sensation Seeking Scale, apart from its thorough endorsement of a stereotypical middle class lifestyle, is its almost complete lack of attention to emotion. This seems incongruous as there is a clear emotional connotation to the way in which 'sensation' as it is construed by the SSS is conceived, the implication being that individuals seek, through sensation, a more positive affective state.

Coming from the other direction, the research on emotion and risk taking has, quite understandably, been concerned primarily with decision making. That emotion can have an influence on decision making, and that emotion in some circumstances may be essentially making the decision, has already been discussed. However, an examination of the influence of emotion on risk taking allows an examination not only of the theoretical issues involves but also raises points regarding the research possibilities in this area, especially within the Adventure Therapy area.

At the forefront of research on the relationship between emotion, particularly positive emotion, on risk related behaviour has been Alice Isen and her colleagues (for example, Isen & Patrick, 1983; Isen & Geva, 1987; Isen, Nygren, & Ashby, 1988). The majority of Isen's work is based on the responses of college students who take part in the research in order to obtain one hour's course credit which they are able to 'risk' in various situations, situations which

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disinhibition, and (d) boredom susceptibility, which measures an aversion to repetition and routine.

typically revolve around being able to bet chips which represent the course credits. Isen has consistently pointed out that the effect of emotion on risk taking is complex, and that it depends on factors such as the nature of the risk (physical risk, social risk, gambling, and so on), the level of risk involved, and whether the potential loss is meaningful or hypothetical. The counterintuitive, but consistent, finding with a (few important exceptions), throughout Isen's work, is that subjects induced with positive feelings are generally more cautious and conservative in their risk preferences and risk taking than control subjects.

Isen & Patrick (1993) tested the notion that positive affect leads to risky behaviour only in low-risk situations. They manipulated the risk level (that the students could lose their course credits), telling different subjects that the bet available to them held a 17 percent chance of winning (high risk), a 50 percent chance of winning (medium risk) or an 83 percent chance of winning (low risk). Their findings revealed that positive affect did not have a uniform effect across the three risk conditions. A significantly greater proportion of positive affect subjects than neutral affect subjects chose to bet in the low-risk condition. Approximately equal proportions of positive affect and neutral affect subjects chose to bet in the moderate risk condition while a smaller proportion of positive affect subjects than neutral affect subjects chose to bet in the high risk condition. Positive affect then, in a gambling situation, promotes an interest in gambling when the risk of losing is low, has little effect when the risk of losing is moderate, and appears to inhibit

interest when the risk of losing is high. This risk aversion was also noted in situations where the risk situation about which subjects were reasoning was a realistic one, that involved a real and personally meaningful loss (Arkes et al, 1988).

This research has important implications in terms of considering 'common sense' models. For instance, the priming or accessibility model of Fiske & Taylor (1984) suggests that persons who are happy are more likely to think about positive possibilities and that they will be generally more optimistic in their decision making, and the model is consistent with what experimental subjects intuit (Isen, et al, 1984). Isen & Geva (1987) investigated this with regard to risk-taking and found that positive mood subjects reported more thoughts about losses and losing in high and moderate risk situations but had fewer thoughts about losing than controls in low risk situations. According to the accessibility model, happy people should have more positive cognitions and should think more about positive possibilities, and should act accordingly, but in this situation they often had more negative thoughts. Isen (1993) argues that this relative risk aversion in positive affect subjects can be explained in terms of affect maintenance - people who are in a positive mood risk losing that state and therefore think and behave conservatively.

Isen's work suggests that, in general, positive affect will discourage risk taking when the risky decision is personally meaningful and relates to a genuine loss, and when the risk of

losing is high. However, positive affect appears to encourage preference for risk when the risk is judged to be low or when the cost associated with the risk is relatively inconsequential. The discussion of the effect of affect on risk taking naturally leads to consideration of the quality of the risk taking decisions that individuals may make. Work by Isen and colleagues (1991) and others (eg Murray et al.,1990) suggests that the effects of affect on cognitive processes involving decisions are task and situation dependant. Important tasks, that allow for creative input, and which provide personally meaningful feedback appear to benefit from positive affect in terms of more efficient information processing. In contrast, positive affect seems to lead to a greater reliance on heuristics, with a possible reduction in task performance, when the task in question is mundane, and of little personal consequence.

With regard to negative affect and decision making, Forgas (1989) compared the effects of positive and negative affect on information search and decision making strategies for both personally relevant and personally irrelevant decisions.[12] Forgas found that sad subjects took longer to make decisions, re-checked information more than positive affect subjects, attended to more information that was not task related, and searched for alternatives rather than attributes of the situation (which, in relation to the experimental task, was less efficient). It is important to note that the work of

[12] It is worth noting that a limitation of Forgas' work is its reliance on bogus feedback to induce positive, neutral, and negative moods - raising the question of whether subjects are influenced more by their mood or by their success or failure on a previous task as they embark on another.

Forgas does not suggest that the actual quality of the decision making of sad subjects was less than that of subjects in positive affective states.

The studies described above are typically undertaken with subjects with no particular (or identified) psychopathology. It is also interesting to note that, in contrast to most other studies of emotion, the majority of the work with regard to risk taking has been done on the influence of positive emotion. However, commonly-made clinical observations of individuals who are depressed include an apparent slowing of decision making processes, a general reluctance to make decisions, marked tendencies towards giving greater weight to risks rather than benefits, and to be generally risk avoidant (see for example, Akiskal & Van Valkenburg,1994; Hartledge et al.,1993; Sweet et al.,1992). There has not however been a substantial amount of empirical research on risk with depressed subjects of the type undertaken by Isen and her colleagues on positive affect. A study that is typical of the type of research that has been undertaken, and which highlights some of the shortcomings of such research, was conducted by Pietromonaco & Rook (1987).

Pietromonaco & Rook studied two groups of students, 25 of whom were depressed and 44 who were non-depressed. The students were given a list of ten decision scenarios and a list of potential risks and benefits which might follow from making a particular choice. For example, one of the problems went: "You recently

purchased a pair of shoes. After wearing the shoes for about a month, you notice that some of the stitches around the sole are coming loose. In deciding whether to return the shoes to the store, you consider the following benefits and risks. Potential benefit: You might get your money back or a replacement pair of shoes. Potential risk: You may waste a lot of time and not accomplish anything" (Pietromonaco & Rook, ibid:401-402). The students were then asked to rate the potential benefit and the potential risk, relating the importance of their possibility, the likelihood that they would occur, and the feeling they would have if the benefit (or risk) were to occur. A composite measure was formed to represent the student's perception of potential risks and benefits. In general, the 'depressed' students rated potential risks more highly and potential benefits less highly than the 'non-depressed' students. The so-called depressed students were also more reluctant than the other students to take the action specified in the scenarios (for example, taking the shoes back in the example described above).

This particular study is instructive as it highlights a number of shortcomings of such investigations. Firstly, as is typical for such studies, the 'diagnosis' of depression was made using a checklist of symptoms of depression (The Beck Depression Inventory). This checklist was developed as a measure of severity of depression and is not a diagnostic instrument. The assumption that a score above a certain point is indicative of the presence of depression in non-clinical populations, particularly in college samples, is rarely warranted (Hammen,1980; Rippere,1994). Furthermore,

depression in this case is treated essentially as an emotion, whereas, as a clinical phenomena, it is more accurately described as a constellation of features, any one of which could potentially have been responsible for the findings. Secondly, as has already been discussed, any analysis of risk requires an analysis of what is actually being risked - specifically, is the risk to be taken highly or only slightly risky? Is the risk personally relevant? What are the features of the potential loss? In a much more general sense, there appears to be only a rudimentary acknowledgment of emotion research and theory. In the shoe example above, emotion theory (from virtually any perspective) would suggest that the authors are making a rather substantial assumption that sadness is the key emotion. It would be just as easy to suggest that anger is the fundamental ingredient in the students' responses.

In short, while the experimental evidence of researchers such as Isen provides some useful signposts regarding emotion and risk, it would seem that there is still a substantial amount of work to be done in the clinical area. A possible avenue of research, which, while being consistent with most of the results discussed above but has more theoretical 'horsepower', regards the distinction between automatic and effortful processing.[13] For instance, Hartledge et al (1993) reviewed the literature and found a clear pattern regarding automatic and effortful processing regarding

[13] Hartledge and her colleagues have three key criteria for both automatic and effortful processing. Automatic processing takes place without requiring attention or conscious awareness, it can occur in parallel with other operations, and occurs without subject intention or control. Effortful processing requires attention with a subsequent inhibition of other pathways, efficiency of the process improves with practice, and the process can be used to cause learning.

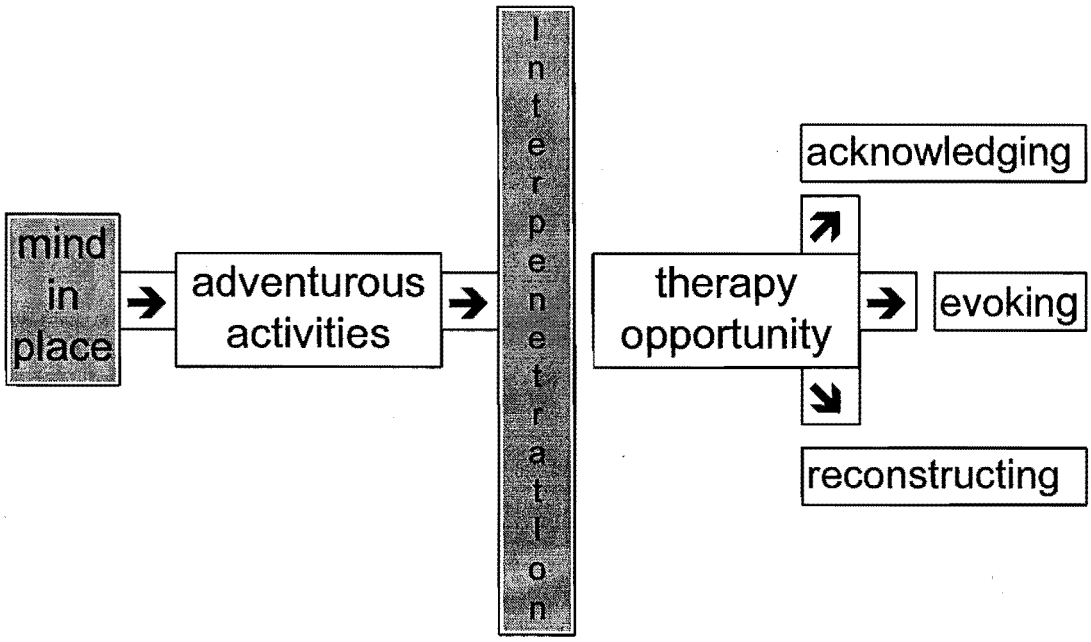
depression.[14] They found that depression interferes with effortful processing with the degree of interference being determined by the degree of 'effortfulness' of the task, the severity of depression, and the valance of the material to be processed. Alternately, depression interferes only minimally with automatic processing. There are clear parallels between automatic processing and emotional processes. Although the automatic/effortful distinction refers to cognitive processes, it would seem that the relation between risk-taking (which requires some cognitive appraisal before it can sensibly be called 'risk taking') and depression could be usefully investigated using such a distinction.

To return to the Adventure Therapy context, the existing research on risk, while being informative, is limited with regard to the processes involved in individuals engaging in, and coping with, activities which they perceive to be risky. Researchers focusing on sensation seeking seem to make an implicit assumption that participation in such activities is indicative of some sort of pathology, while the risk research generally examines risks (such as gambling) which do not mesh easily with the perceived or objective risks inherent in Adventure Therapy.

[14] Depression was defined in numerous ways for various studies although, in general, there was a greater reliance on clinician diagnosis, with the use of scales to indicate severity.

EMOTION AND ADVENTURE THERAPY: A MODEL

Having assembled the raw materials of an introduction to Adventure Therapy, emotion, the role of emotion in psychotherapy and the attendant therapeutic implications, it is appropriate to begin building a model of the way in which emotion may contribute to the process of Adventure Therapy. The aim of constructing the model, as was alluded to in the introduction, is to provide a basic, theoretically informed framework, that will serve as the basis for research. In keeping with the themes of the preceding chapters, the model is predicated on four key concepts: (1) the mind in place, (2) the adaptive significance of emotion, (3) the interpenetration of adventurous activities and (4) the centrality of emotion to the therapy process.



Simply put, the model, pictured above, suggests that an individual comes to the Adventure Therapy process with a particular mind-in-place and participates in adventurous activities that have various adaptive implications. Participation in these activities precipitates an interpenetration of the mind-in-place, the result being an opportunity for therapy. The opportunity can then be taken up in terms of acknowledging, evoking and restructuring with the end result being a shift in mind-in-place. That then, is the model in a nutshell. However, on the basis that any model that can only be put in a nutshell probably belongs there, described below are the components and their interrelationships in more detail.

In Chapter 3, Alfred, apparently determined to jump to his death and girded up against the expected appeals from his psychiatrist and other specialists in such behaviour, did not kill himself because of the demands of an obnoxious police officer inadvertently provoking a shift in Alfred's mind-in-place from committed suicider to law-abiding citizen. The shift in Alfred's mind-in-place was not effortful but occurred in a largely automatic fashion in response to an unexpected pattern of environmental input. Clients arrive in Adventure Therapy programs as the result of a persistent mind-in-place, typically one which has become problematic in some way. It is important to note that while there is a temptation to think of the mind-in-place as purely cognitive, as it is conceived here, the mind-in-place is a holistic construct that

refers to all aspects of an individual's being at a particular time. This will necessarily include emotional, cognitive and bodily aspects.

The suggestion that there are substantial shifts between 'minds' is, for some, better explained in terms of an automatic adjustment in the threshold of accessibility for the use of particular constructs. This construct accessibility model, on the basis of its parsimonious nature, presents a substantial challenge to the mind-in-place approach and deserves consideration. In an often referred to study, Srull & Wyer (1979) presented subjects, who thought they were participating in a sentence construction task, with words related to either hostility or kindness. Following the presentation of the words subjects were asked to rate their impressions of a person presented to them. Those who had been presented with more hostile words as part of the bogus sentence construction task rated the hostility of the target person as higher than that of those who had been presented with kind words.

These types of results fitted comfortably within the construct accessibility model but Teasdale (1997) reports more recent work, conducted along similar experimental lines, such as that by Bargh *et al. (*1994), that is not as easy to explain in terms of construct accessibility. Bargh and his colleagues were able to demonstrate that the prior presentation of achievement-related words increased measures of related goals and motives. Subjects were primed with either achievement-related or neutral words and asked, under the

guise of a 'language ability' test to make as many words as they could out of scrabble letter tiles. The experimenter told the subjects that she needed to leave to run another experiment but that if she could not get back she would give them the signal to stop creating words over an intercom. The subjects were surreptitiously observed, and received the instruction to stop apparently without any observer present. Of interest were the subjects who persisted with the task after being told to stop, with persistence being assumed to reflect the subject's level of achievement motivation. While 22 percent of the subjects who were primed with neutral words persisted with the task, 55percent of those primed with achievement-related words persisted. As Teasdale points out, such results clearly indicate that the mere presentation of achievement words had automatically triggered a related motivational state, something that is difficult to explain in terms of simple construct accessibility. Such results are much more consistent with the mind-in-place notion of changes in environmental stimuli resulting in an automatic shift across the spectrum of interpretation, behaviour and motivation.

The construct accessibility model has been used to explain the well-researched tendency of depressed individuals to interpret experience more negatively (Haaga *et al.* 1991). However, in a recent study (Teasdale *et al.* 1995), Teasdale and his colleagues found a fascinating conterintuitive aspect of depression. Their research suggests that mood effects operate not at the level of individual negative constructs (as is suggested by the construct

accessibility model) but rather at a more generic or higher level of representation more consistent with the mind-in-place conception. These researchers suggested that although depressed patients may regard success or social approval as unlikely, if such events were to occur they would be interpreted more positively than in a non-depressed state (where personal worth is thought to be relatively independent of social approval or one's success or failure on a particular task). Furthermore, they suggest that the interrelationships between constructs become dysfunctional in depression, resulting in closer than usual relationships between things such as the view of self and social approval or success on a task.

In a study conducted by Teasdale *et al.* (1995) subjects were given a number of sentence stems and were asked to complete them with the first word that came to mind. The sentences were constructed so that dysfunctional models (those implying a close dependence of personal worth on the positive attention and approval of others) would result in positive sentence completions. For example, one of the sentences ran: 'For everyone to look to me for guidance and advice would make me _____'. Those using a dysfunctional model would complete the sentence positively (for example, 'happy') while a those with a more functional or realistic model would lead to more negative completions (for example, 'exhausted'). This research design cleverly separates the construct accessibility view, which would predict that depressed patients would make more negative

responses, and the mind-in-place model (which concentrates on interrelationships and dependencies between constructs) which would predict that the depressed patients would give more positive completions, a tendency which should decrease with recovery.

The results of the investigation clearly support the mind-in-place view. Depressed patients did indeed give more positive responses than non-depressed controls, and at the three month follow-up, those depressed patients who had improved gave more negative responses. Conversely, those whose mood had deteriorated at follow-up showed a marked increase in positive responses. Teasdale maintains that the results, which he and others have subsequently replicated, support the view that negative depressive thinking is better explained in terms of changes in representations that reflect the relationships between key aspects of experience, rather than by referring to changes in the accessibility of individual cognitive constructs.

In terms of the current model, this is an important point because otherwise it would be clearly more expedient to target specific thoughts and to challenge them, in a form of cognitive 'panelbeating' rather than taking a more holistic approach as is being suggested here. This is of course what a crude version of Beck's Cognitive Behaviour Therapy would resemble. While the identification of negative thoughts is still a key element of CBT, it is interesting to note that a recurrent theme in the recent CBT

literature is the need for an integrative approach to psychotherapy.[1]

Such a view of mind-in-place also suggests that any form of psychological treatment needs to create in some way either a way of wheeling in new more adaptive minds or, more probably, reinstituting already existing minds while excluding the less useful ones. One approach to this (the one which Teasdale recommends) is to concentrate on creating a 'store' of alternative depression-related models which are associated with as a wide a variety of eliciting contexts as possible. Such an approach has clear merit but relies on being able to identify exactly what the possible eliciting contexts are, a task which the mind-in-place model suggests would become a Sisyphean struggle due to the potentially infinite combinations of eliciting contexts.

Another approach is to provide a foundation by working within an environment that has particular salience due to its adaptive implications for the individual. Interestingly, Beck, the founder of cognitive therapy, appears to offer tacit support for such a view. He writes:

> *The modes, consisting of integrated sectors or suborganizations of personality, are designed to deal with specific demands or problems. The "primal modes" of most interest for the study of psychopathology include the derivatives of ancient organisations that evolved in prehistoric circumstances and are manifested in survival reactions, but also, in an exaggerated way, in psychiatric disorders* (1996:2).

[1] See the volume "Frontiers of Cognitive Therapy" (1996) and in particular a chapter by Beck himself entitled "Beyond Belief", which highlights the need for an integrated view.

It is suggested here that an effective means of addressing problematic minds-in-place is to initially work within a context that makes deep adaptive sense to the individual in terms of survival. Furthermore, as has been frequently stated in earlier chapters, emotion is at the forefront of the provision of adaptively relevant information to the organism. This suggests that adaptive activities that have substantial emotionality attached to them will be most useful. Of course, in keeping with the theme of the current work, it is suggested that adventurous activities provide a readily accessible means of entering such a context.

What is it, then, about adventurous activities which would result in access to fundamental adaptive information? To set the stage, consider briefly the context within which the emotions are generally thought to have evolved in humans. In evolutionary terms, give or take a dozen millennia, our evolution reached its current form 40 000 years ago. The world, for almost all of humanity during almost all of our history, was small, tribal and stable in terms of environment. We are the way we are because of the way the world *was* for us 40 000 years ago. That world, however, has changed, especially for the western industrial 'us'. Consider what would now be thought of as an extended wilderness journey of ten days. Technological changes in equipment and the journeys intent excepting, the similarities rather than differences between modern humans and our ancestors are apparent. Both groups need to walk, to carry or find food, to

cooperate to survive and to adapt to environmental demands in terms of weather, terrain, wildlife and so on.

It is important to clearly point out that what is being envisaged here is not a 'back to nature' therapeutic intervention, with its attendant philosophical baggage, but rather the formulation (through particular activities) of an environment that, in an adaptive way, 'makes sense'. As was seen in Chapter 1, it is a common enough theme in the Adventure Therapy literature that an unfamiliar environment is seen as a key part of the Adventure Therapy process. What is being suggested here is an extension of this notion, in that the outdoors may indeed be immediately unfamiliar to participants, but that in terms of evolutionary history, it is quite familiar and is therefore an appropriate context for the psychotherapeutic exploration of emotional themes.

Another important aspect of engaging in adventurous activities is the potential such activities have for allowing participants to gain a wider perspective of their problems and symptoms. It is tempting to think only in terms of the activities providing compelling distraction from current difficulties in much the same way as has been suggested by Fennell *et al.* (1987) who pointed out that some tasks are incompatible with depression.[2] But what is being suggested here is that engaging in such activities prompts

[2] Recent developments in cognitive therapy for psychosis suggest that distraction can provide some relief from hallucinations (for an overview see Haddock & Slade, 1996). Similarly, anecdotal reports from Adventure Therapists suggest that clients, when engaged in highly focused activities such as climbing and abseiling, do not experience hallucinations to the same degree.

participants to be move from 'being' only their negative problems and symptoms to a situation in which, while they may still experience such difficulties, the difficulties are experienced as part of a wider context.

Rather than examining all the possible activities which Adventure Therapy participants may engage in, a consideration of the features of rock climbing and abseiling with regard to the role of emotion will serve to illustrate the potential utility of such activities. Heights appear to be naturally fear-inducing in humans. Using an apparatus called the visual cliff,[3] Campos and his colleagues (1978) were able to provide indirect evidence (based on heart-rate[4]) that infants (six to seven months of age) who were placed on the deep side of the cliff were capable of detecting a drop and responded with fear. Interestingly, although infants as young as four months of age have at least basic depth perception, they do not respond fearfully to the visual cliff. In what has become an ongoing series of experiments, Campos and his colleagues have established that the emergence of fear is associated with the development of depth perception plus approximately three weeks of crawling or self-locomotion. With regard to Adventure Therapy, it is notable that climbing and abseiling are a part of the vast majority of programs and that major programs such as Project Adventure use ropes courses as the basis of their therapeutic

[3] The visual cliff is a glass topped table of which one side has a chequered cover very near the glass top and on the other the glass is separated from the cover by approximately 60 centimetres.

[4] See Fox & Calkins (1993) for an overview of the use of heart-rate and vagal tone as a means of investigating infant emotion.

work. Although there does not appear to be any particular research on why climbing and abseiling should be such an integral part of most Adventure Therapy programs it would seem that it is these activities that are most likely to cause fear, followed by positive emotion as the result of having completed the activity.

It is at this point that the need for research based on people's emotional processes during such activities becomes clearly evident. While the research on coping and risk described in Chapter 5, and the anecdotes of practitioners and reports of participants strongly suggests that emotion will be a dynamic and influential process as people engage in such activities, there is no body of literature to delineate exactly what is occurring. While 'processing', as described in Chapter 1, especially with regard to how individuals 'felt', has become commonplace as part of the Adventure Therapy process, there does not appear to have been, as yet, any systematic research.

What is clear, however, is that for most, participants, climbing and abseiling over substantial drops will be a frightening experience to greater or lesser degrees. Experience with clients and anecdotal reports suggest that participants experience considerable anticipatory anxiety, which is often related to peer or self evaluations as to how they will cope, followed by fears about not being able to escape from the situation, and fears about injury or death when actually engaged in the activity. With the exception of fears about animals, this is entirely consistent with the factor

analytic work of Arrindell *et al.* (1991) on self-reported fear of large samples of adults. This work identified four primary factors, all of which have clear adaptive significance: (1) fears about interpersonal events or situations, (2) fears related to death, blood, injuries and the like, (3) fears about animals and (4) agoraphobic type fears. However, what is also remarkable about observing clients who have completed the activity is the speed with which the fears dissipate and with which exhilaration sets in.[5] The often reported experience of people who have had a narrow escape from danger, where some time later they have the actual experience of fearfulness, does not seem to occur often in Adventure Therapy situations, a phenomenon that if substantiated, would provide an interesting avenue of research.[6]

The main point to be made here is that rock climbing and abseiling typically provide participants with an experience that, with emotion at the forefront, is almost completely absorbing, pervading all aspects of an individual's current being. This is what is being referred to by the concept of **interpenetration** where, following Lazarus (1991), cognitive, motivational and emotional activities, all focused on actions within an environment, are engaged. Lazarus maintains that this is the essence of therapeutic change and what is being suggested here is that interpenetration within an adaptive environment is a precursor to therapeutic change, providing a

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[5] See Ruch (1993) for an overview of exhilaration.

[6] Izard (1991) provides a brief discussion of 'delayed' or 'postponed' fear and points out that although it is a widely recognised phenomenon, there are, as yet, no substantial explanations as to the processes involved. A possible explanation is that as one function of fear is to organise and motivate escape, if there is no escape possible the fear may only add to the danger.

context within which a shift in mind-in-place can occur. This interpenetration suggests an unavoidable adaptive integration that can serve as a reference point in proceeding therapeutic interventions.

Any reference to the need for integration suggests that a key aspect of psychopathology is a lack of integration or what Lazarus (1991:461) refers to as *disconnections.* He suggests that there are four types of disconnection:

1. *Within the mind* - what has traditionally been referred to as intrapsychic conflict.
2. *Between the mind and environment* - for instance where a threat is appraised inappropriately, resulting in anxiety, guilt or shame, and when real threats are unapprised or when the coping process employed is inappropriate.
3. *Between mind and action* - consisting of two subvarieties, actions failing to conform to intentions, and intentions not expressed in action.
4. *Between environment and action* - which refers to a lack of fit between appraisal or coping and the environment.

By examining these *disconnections,* it is apparent that each of the therapeutic schools described in Chapter 3 emphasise particular disconnections. For instance, a disconnection within the mind clearly fits most easily within the psychoanalytic school, particularly the later thought of Freud. While some may argue that it is little more than terminological obfuscation and that we may as

well talk about the unconscious, the notion of automatic versus effortful processing which was raised in Chapter 5 suggests that, particularly with regard to anxiety, there is a disconnection between these two modes of processing. What is also apparent, however, is that the emphasis on one particular disconnection results in therapy that does not connect with other aspects of the holistically conceptualised mind. Or, to apply the mind-in-place conceptualisation, an intervention that does not activate all the aspects of a more adaptive mind-in-place is unlikely to bring that mind-in-place to the fore.

Interpenetration, then, prompts the implementation of a new mind-in-place and, if of sufficient salience to the individual, the experiences which prompt the interpenetration will provide a kind of 'home base' for an individual's own therapy. At this point, it is worth attempting to make some sort of distinction between 'therapeutic' and 'therapy'. It would seem that most Adventure Therapists actually work within a therapeutic realm, where the activities provide a reorienting and healthy (in the broadest sense of the word) experience for participants. Within this realm it makes sense that adventurous activities should be generally 'useful', as is evidenced by the diverse populations described in Chapter 1. It is also important to remember that for many people the activities which comprise these programs are recreational pursuits, engaged in presumably because people perceive benefit from doing so.

Therapy however, as it is being conceived of here, is a matter of intentionally (both on the part of the client and therapist) addressing specific concerns, and using specific techniques, within the holistic framework presented above. The transition into therapy also presupposes that the therapist is cognisant of the general principles of psychotherapy and the specific difficulties with which clients may present. This distinction has been a contentious issue within the Adventure Therapy world, with the inaugural world conference in 1997 devoting considerable time and debate to the issue.

The model which is being presented here suggests that the first two aspects (adventurous activities and interpenetration) are *therapeutic* but that once the interpenetration of the activities is utilised to address specific concerns, participants are engaged in *therapy.* The model therefore has two stages, with the way in which interpenetration is utilised constituting the boundary between the two stages. What may often occur, however, is that individuals essentially self-prescribe the first stages of the model so as to 'get over' particular difficulties, a process which facilators of these activities may wittingly or unwittingly participate in. Perhaps the commonest form of this self-prescription is a desire to overcome a fear of heights by going climbing or abseiling. The obvious danger with this form of 'treatment' is the potential for sensitisation (Andrews *et al.*, 1994) thereby actually lowering the likelihood of seeking appropriate treatment. Mitten (1994) also points out that there is a danger when depressed individuals who

have previously enjoyed an activity such as rock-climbing in a supervised setting try to lift their mood by climbing themselves. The nature of depression, with its attendant cognitive deficits (such as attentional and processing speed deficits, see for example, Lezak, 1995) may result in poor judgement, which in an unsupervised situation, places the individual in real danger as opposed to the perceived danger of Adventure Therapy.

Proceeding into the therapy realm, the model suggests that the interpenetration of adventurous activities, with their high affective component, provides a valuable opportunity for therapy. The interpenetration provides, for both the therapist and client, a 'back stage pass' to the way in which the client is processing important adaptive information. For example, interest for the current work was piqued by anecdotes from Adventure Therapy practitioners and personal observation of clients who, despite being in what were fear provoking situations, became angry and abusive to both instructors and other participants to the exclusion of both support and assistance. This is the sort of information that would be unlikely to be elicited with such clarity in a standard assessment situation.

Assessment is a key part of any therapy and it would seem that, in contrast to the plethora of single trait measures (for example of anxiety or anger), assessment in the context of Adventure Therapy programs provides a valuable insight into the client's way of adapting to the world. Before proceeding to any particular

'treatment', an assessment needs to be made in terms of the way in which the client is processing information. Greenberg (1993) suggests that there are four key areas which should be considered when making a 'process diagnosis', all of which could be undertaken in the course of an Adventure Therapy program:

1. *Biologically adaptive primary affective responses* - referring to the experiences of emotion that provide information about an appropriate response to the environment.
2. *Secondary reactive emotional responses* - in a way that reflects Lazarus's (1991) distinction between primary and secondary appraisal as described in Chapter 5, these responses are secondary to the primary generating processes. They are perhaps most easily conceived of as defensive responses.
3. *Instrumental emotional responses* - the emotional responses that individuals have learned as a way to influence others, such as crying to elicit sympathy or using anger to dominate.
4. *Learned maladaptive primary responses* - although, as has been discussed at length above, emotions are generally adaptive, in the case of sustained negative contingencies in childhood it may be possible for individuals to learn maladaptive primary responses. The example presented above, of an individual becoming angry in response to fear, which has the effect of excluding assistance or care, could be conceived of in terms of a learned maladpative primary response.

The focus of the model is on the emotional processes involved in Adventure Therapy, and their contribution to therapy, and as such, attention now turns to particular applications. These applications are based on the therapeutic implications presented in Chapter 4 and are organised under the general framework of emotional change processes which relate to acknowledging, evoking and restructuring.

It is important to remain mindful that no attempt is being made here to encompass the spectrum of possible types of therapy techniques and it is not being suggested that emotional intervention processes are the be all and end all of therapy. However, in light of the theory and research which has been presented in previous chapters, to ignore emotional interventions in therapy is to risk closing the shutters on a basic aspect of human experience, thereby fundamentally compromising the potential effectiveness of therapy.

Acknowledging emotion, as was described in Chapter 4, is largely a matter of assisting clients to attend to their emotions. In terms of the therapeutic implications discussed in Chapter 4, the two factors which seem most applicable are the need for the complete processing of emotion to enhance adaptive functioning and the personal clarity and control that results from cognisance of elicitors of emotion. In terms of the primary change process

involved, the processes involved fall under the general rubric of *experiencing*.

In general, techniques designed to train clients in attending to emotion are based on the cognitive construction of a relevant situation.[7] The difficulty regarding such training, which was alluded to in Chapter 3 with regard to the work of Bandura, is captured in a distinction that is now over a hundred years old. William James (1890) referred to *knowledge by acquaintance* and *knowledge by description.* Knowledge by description is knowledge *about* something whereas knowledge by acquaintance involves direct experience. Bandura (1997), in an empirically based analysis, points out that verbal persuasion or 'talking' is not as effective as actual experience in learning.

Adventure Therapy activities, as a result of their ability to provoke emotion that is part of a broader adaptive context, clearly provide a valuable context for the exploration of experiencing emotion. Clients can be directed towards attending to bodily sensations, action tendencies and all the other aspects of emotional processing. In terms of Adventure Therapy, it would seem that the activities provide a context for learning to attend to emotion that is personally non-threatening in terms of the particular difficulties that a client may bring to therapy. For example, for clients suffering from Post Traumatic Stress Disorder, a feature of which is emotional numbing (DSM-IV), to attempt to learn (or re-learn) to

[7] See, for example, Gendlin's (1981) description of how clients may be trained in 'focusing'.

attend to emotion only in the context of their traumatic experience is likely to be counterproductive (van Der Kolk, 1996). However, as Levine (1994) explains, women who have experienced sexual assault benefit from being able to experience 'warded off' emotions within an Adventure Therapy context before proceeding to examining their traumatic experience within a conventional counselling context.

Also mentioned above with regard to acknowledging was that awareness of elicitors provides personal clarity and control. As has been suggested with regard to climbing, humans havve an apparently hard-wired fear of heights. There is, in other words, a clear elicitor. A feature of anxiety disorders, and Generalised Anxiety Disorder in particular, is fear that, for sufferers is unattributable to any particular cause (Rapee,1990). In terms of using adventurous activities with such clients, there would seem to be potential for using such activities as the basis for beginning to orientate clients to the various aspects of being frightened. By being able to reflect on a clear eliciting stimuli, clients may begin to identify other eliciting stimuli, thereby gaining some sense of mastery and control (Bandura,1997).

As has been discussed in the preceding chapters, the evoking of emotion with a view to promoting a cathartic effect has been almost synonymous with emotional change processes. In terms of the model presented, the use of adventurous activities in order to promote a cathartic experience for an individual is not consistent

with the adaptive framework within which the activities have been conceptualised. Furthermore, suggestions that all that is required to provoke a cathartic effect is a highly emotional experience which will then produce a therapeutic result, seems to presuppose that one emotional 'episode' is much like another. However, in terms of the mind-in-place conceptualisation, the emotion that is evoked by activities such as climbing may provide valuable insights for both the client and therapist into the nature of the current mind-in-place. This is based on the information processing perspective and more particularly on the work of Leventhal (1984) who proposed that the activation of one component of a schema is likely to result in the 'reeling off' of the entire schema, as was described in Chapter 2.

In terms of emotionally focused interventions, Greenberg & Safran (1987) suggest that emotion leads to accessing what they describe as 'hot cognitions'. While their distinction between 'hot' cognitions, which are affectively laden, and 'cold' rational, affect free thoughts seems, to mix metaphors, rather black and white. It has an intuitive appeal in terms of an effective means of accessing key therapy issues. Once clients have a clear experience of a particular emotional process, accessing problematic or traumatic aspects of a client's world may be as simple as asking "are there other times when you have felt like this?". This type of approach is consistent with Frijda's (1986) analysis of catharsis presented in Chapter 4 where, rather than 'letting off steam', the emotional experience is activated, the context is personalised, and the

completion of a previously interrupted sequence is facilitated. Once again, in general terms, the features inherent in the activity provide a general context from which to proceed on to therapy which is more closely focused on the client's particular difficulties.

The third general category of emotionally focused intervention is restructuring. Virtually all the techniques and procedures that have been discussed could potentially fall under this category. The emphasis here will be on restructuring as it relates to interpersonal aspects of Adventure Therapy. Considered briefly are both the adaptive aspects of interpersonal interaction in the course of adventurous activities, and the unique aspects of the therapeutic relationship in Adventure Therapy.

As was pointed out in Chapter 4, a therapeutic implication of the research on emotion is that awareness of the communicative aspect of emotion enhances interaction. In terms of psychotherapy, Kiesler (1982, 1986), in a similar way to Sullivan (1953), suggested that 'problems in living' are the result of inappropriate, disordered, or inadequate interpersonal communication. Defined in interpersonal terms, a client's experience of emotion is seen as a significant part of interpersonal transactions. Kiesler maintained that these transactions, rather than being linear in terms of a single cause, are circular, where the effect of the transaction shapes the meaning of the interaction. The problems that are typically the focus of therapy are

communicated as a part of this process with emotion constituting an important 'channel' of that communication.

Consistent with the theme that is emerging within the model, the conventional therapy setting, typically an office, limits communication to a particular style. This restricted medium for communication will tend to present emotional difficulties as emerging from 'within' the client rather than as a part of how the person is in the world. The work of anthropologically oriented theorists such as Lutz and White has already been mentioned and suggests that emotion is not only 'within' as is suggested by the dominant psychobiological models but is also 'without', existing within a social world where the currency of human transaction is communication.

Out of the office, and in an adaptive environment, there is potential for the observation of a much broader field of communication. As has been already pointed out, the control precedence of emotion that occurs within the context of some adventurous activities provides a 'backstage pass' to an individual's particular reactions to a broad range of environmental features. For instance, Adventure Therapy is almost invariably carried out in small groups, within which activities are often formulated so as to engender group co-operation and trust. Most people for instance, are familiar with 'trust falls', where an individual falls backwards and is caught by the other members of the group. Commonly, individuals will seek reassurance from the group that they will indeed be caught,

communicating their apprehension not only verbally, but also emotionally with visible signs of apprehension. The fear of the individual alerts other members of the group to pay attention and typically the group will reassure the individual that they will indeed catch them. Climbing, where an individual needs to rely on a belayer to hold the rope in the event of a fall, elicits similar communication.

By broadening the scope within which the communicative aspects of emotion can be elicited, both therapist and client can gain insights into the communicative function of emotion for the client, and more particularly, any anomalies in this communication that may be problematic. As was discussed in Chapter 4, therapists may often feel 'pulled' to make a complementary response to a client's emotion in a therapy session, which in turn elicits a repetition of the client's actions. What is often overlooked, however, is that there is an implicit assumption that the way the client responds in the context of a therapy session is the way they respond in other situations. Such a view does not seem to take into account the particular dynamics (such as power imbalances) that may be part of such an encounter. Having said that, the therapeutic relationship is, as has been suggested in Chapter 4, a key therapeutic ingredient.

The therapeutic relationship is usually one where it is tacitly agreed that, in contrast to most intimate relationships, only one person (the client) will share their most intimate experiences and

concerns with their attendant emotions, with another person (the therapist) who does not reciprocate with the sharing of the intimate details of his or her own life (Butler & Strupp, 1991). Furthermore, there is an understanding that the client will describe the problematic aspects of life, rather than having the therapist present in the client's everyday environment. In contrast, the typical Adventure Therapy environment involves both client and therapist spending considerable amounts of time in each other's company, while simultaneously involved in what can be everyday activities. This is particularly true of wilderness oriented programs, where therapists and clients are often together for extended periods and where the everyday aspects of life, including cooking, travelling and sleeping are shared.

At this point, it is worth noting some of the special considerations that arise in this environment with regard to the therapeutic relationship, and the ethical considerations that subsequently need to be taken into account.[8] As is apparent from the preceding discussion, a key part of Adventure Therapy is taking clients both out of their everyday environment, and also into situations that are well outside the client's 'comfort zone'. In a standard therapy situation clients may often become dependant to one degree or another on the therapist as a result of the support they find. In an Adventure Therapy context, the same client may not only be dependant on the general support of the therapist but also for very

[8] Mitten (1994) provides one of the most thought-provoking discussions of ethics in Adventure Therapy particularly with regard to the patriarchal history of the field and in particular, the concerns of women in light of this history.

basic needs such as food, shelter and protection, as well as the technical skills required to participate safely in some activities. When one also considers that clients are most likely coming to Adventure Therapy as the result of problematic aspects in their lives which may have resulted in increased feelings of vulnerability there is obviously a need to be constantly watchful as to professional boundaries and ethical practise.[9]

With such concerns clearly in mind, in terms of the current model such considerations are also indicative of the potential for restructuring, particularly in terms of what could broadly be called a 'corrective emotional experience'. Greenberg (1993) suggests that there are two key elements required if successful emotional restructuring is to occur. Firstly, as has been discussed above, relevant activating information must be provided to the individual. The intrinsically adaptive nature of the Adventure Therapy ecology provides considerable activating information. Secondly, and most importantly with regard to the corrective emotional experience, *novel information* must be provided that is incompatible with existing structures, or mind-in-place. In light of the research presented in Chapter 4, it would seem that the initial medium through which these interpersonal elements are communicated is affective attunement.

At this point it is apparent that there is a tension between resisting perpetuating a possibly maladaptive 'pull' from the client while still

[9] For an overview and interesting analysis of professional boundaries, see Peterson (1992).

being able to demonstrate the attunement that is so crucial to establishing the therapeutic alliance. While there is no straightforward solution to this tension, it is possible that in a 'standard' therapy setting the problematic 'pull' is accentuated because of the sharp focus that is being drawn on the very aspects of the individual's experience that are likely to elicit it. When the environment, both in terms of physical surroundings and activities, is less focused on the individual's particular difficulties or diagnosis in favour of his or her 'being', it is possible that there is less potential for becoming enmeshed in dynamics which are likely to be well entrenched. Instead there is the potential to demonstrate an attunement to a more diverse range of emotions, thereby widening the scope for the provision of novel information.

Perhaps the most obvious example of this is the lack of scope within a conventional therapy context to attune in an immediate way to a client's happiness. In general, as was apparent in Chapter 3, psychotherapy practice is focused on the experience of negative emotions. However, the activities which are an integral part of Adventure Therapy are designed to make successful completion likely. This means there is far more opportunity for the therapist and other group members to participate in a particular clients exhilaration or happiness at the achievement of a goal (Averill & More,1993; Ruch,1993).

The other aspect which is apparently unresearched is the effect of group members attuning to a particular clients emotion in an

Adventure Therapy setting and the subsequent impact such attunement may have in terms of providing a corrective emotional experience. There is, of course, a considerable body of research and theory which demonstrates the impact of others on the experience of emotion and the expression of emotion in groups.[10] It is important to keep in mind that, as was pointed out above, the so-called 'emotional disorders' are not only a matter of what comes from within an individual but also of that individual's emotional being in the world and the reactions of others to that being. Being able to experience the attunement of others to experiences which are not 'disordered' clearly has the potential to deliver significant novel information that can lead to the restructuring of emotional reactions.

Restructuring, evoking and acknowledging, as they are being presented here, are probably best envisaged as a type of ecological constructivism. By being a part of an adaptive physical and interpersonal environment, a participant is presented with novel information about needs and concerns that facilitates both the egress of a problematic mind-in-place and the ingress of a more adaptive mind-in-place.

Summary

The model presented above, of the role of emotion in Adventure Therapy, is a two stage process which suggests that the experience of participating in adventurous activities is therapeutic

[10] See Strongman (1996) for an overview.

in and of itself, and that participation can, in the second stage, provide a valuable substrate for therapy. The second stage of the model was presented in very general terms, but in practice would be tailored to an individual client, based on a thorough assessment of what particular issues are presenting as problematic. The model does not purport in any way to cover the gamet of what *therapy* may involve, but does suggest that any intervention that does not involve an emotional component will be therapeutically underpowered.

FUTURE DIRECTIONS

The preceding discussion suggests that Adventure Therapy provides an adaptive context for addressing a broad range of 'problems of living'. The focus has been on exploring the way in which emotion may contribute to the therapeutic process. Based on the research and theory presented, there is good reason to suspect that, as is the case for other approaches to therapy, emotion is a key therapeutic element in Adventure Therapy. The model which has been presented is an attempt to describe a way in which emotion may be conceptualised as operating within the Adventure Therapy context.

While the model is grounded in research and theory from both the academic and therapy literature it is speculative and requires substantive research. As was apparent from the research on coping and risk, substantive research often reveals counterintuitive features which result in the revision of existing models. However, the coping and risk research also revealed that, while there are some interesting suggestions as to the processes at work, there is a clear need to investigate Adventure Therapy in a naturalistic context. The Adventure Therapy research that does exist, perhaps driven by the need to demonstrate efficacy, has tended to focus on general outcomes such as broadly defined improvements in self-esteem. What is required, however, is process research that illuminates what occurs in course of Adventure Therapy.

Rennie & Toukmanian (1992), following Bruner (1986), describe two approaches to research, *paradigmatic* and *narrative,* that are used within the psychotherapy domain. The paradigmatic approach is logico-scientific where demonstrative reasoning gives rise to hypotheses about the causes of relations between phenomena, and verification of hypotheses is taken as evidence of general laws. The paradigmatic approach, consistent with the realist philosophical attitude which underpins it, suggests that there is a world external to the observer that can be understood objectively. In general, the paradigmatic approach has prevailed in psychotherapy research and similarly, Adventure Therapy research has tended to reflect this with an emphasis on pre and post measures across various dimensions.

The *narrative* approach in contrast to the deductive, demonstrative, and quantitative approach of the paradigmatic orientation is inductive, hermeneutical, and qualitative. The narrative approach supposes that individual reasons and experiences are not only particular, but that they are also the product of both individual and social interpretation. Without entering the debate about the compatibility of such approaches[1] it would seem that methodological fundamentalism regarding either perspective is likely to limit rather than expand what can be known about the role of emotion in Adventure Therapy. For instance the

[1] See Polkinghorne (1988) and Miles & Huberman (1984) for representative discussions of the utility and compatibility of the two approaches.

experimental work of Teasdale (1997) brought to light higher order interrelationships indicative of a mind-in-place which could subsequently be elaborated by the 'collective recursion' that Crawford et al (1992) used to investigate gender and emotion.

In terms of emotion in Adventure Therapy there is clearly a need to engage in research which taps the *experience* of participants in such programs. For before any suggestions can be made about the most efficacious emotionally focused interventions, there is a clear need to hear what occurs for participants. One of the questions that looms largest is whether or not those who have emotional disorders have the same experience of adventurous activities as those who do not, especially with regard to emotional regulation processes. The emotional experiences of particular groups is also an important avenue of research. Of particular concern is the urgent need to explore the experiences of women within Adventure Therapy contexts. While an excellent start has been made by Cole, Erdman & Rothblum (1994) on outlining the experiences of women within what has traditionally been a men only space (both in terms of environment and ideology), the work of Crawford *et al* (1992) suggests that the emotional experience of women within such programs may be quite different to that of male participants.

The model which has been presented provides a conceptual framework within which substantive investigation of the role of emotion within Adventure Therapy might proceed using a variety

of methodological approaches. It is expected, and hoped, that such research would contribute to the revision and elaboration of the model.

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